KY EQRO ANNUAL REVIEW
March 2014
Period of Review: January 1, 2013 – December 31, 2013
MCO: Humana CareSource

Final Report 9/12/2014

Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
19.1 QAPI Program			**General Recommendation for Humana CareSource:** Policies, procedures, reports and documents should be consistent with regard to branding/MCO name and specific to Kentucky Medicaid. The full MCO name, Humana CareSource, should be used consistently.	Humana-CareSource is in the process of reviewing policies, procedures, reports, and documents to ensure branding consistency with the "Humana-CareSource" name and logo. Additionally, we are reviewing all policies and procedures to ensure they are Kentucky Medicaid specific.
The Contractor shall implement and operate a comprehensive QAPI program that assesses, monitors, evaluates and improves the quality of care provided to Members.		Substantial	Assessment, monitoring, evaluation and improvement activities are described throughout the Humana CareSource (OH-KY) and Humana local market (KY) program descriptions: • 2013 Quality Improvement Program, Humana CareSource (overview p. 6-9) • 2014 Kentucky Market Addendum, Corporate Quality Improvement Program Description, Medicaid Managed Care Program. Approved 11.8.13. (overview p. 3-4) Implementation is addressed by the Humana CareSource Quality Improvement Program Annual Evaluation January 1 – December 31, 2013. • It is noted 2013 was a start-up year; baseline data was collected, with	Humana - CareSource agrees with the recommendation. A side by side comparison of HCS organizational chart including committee descriptions and the Humana KY Market Addendum organizational chart including committee descriptions will be conducted by the CareSource QI Manager and the Humana Regional QI Manager, East Region, and updates made to both documents as needed.

Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
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			performance measurement planned for 2014. • Empty table shells for 2013 and 2014 measurement (e.g., HEDIS, Access and Availability, CAHPS, Provider Satisfaction) were provided, as were barriers based on experience and improvement plans. • Limited available 2013 data included summary numbers for service operations calls, grievances, and appeals. • However, quarterly QAC (Quality Assessment Committee) minutes and QAPI Work Plan updates show reporting, analysis (categorization and trending), discussion and planning around quality of care metrics. Per the Humana KY Market Addendum org chart the committee structure is: Corporate QIC East Division (ED) QMC Humana CareSource QAC (Quality Assessment Committee) CareSource QEC (Quality Enterprise Committee) Per the Humana CareSource QAC charter, QAC reports both to the ED QMC and the	

Final Report 9/12/2014

Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
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			CS QEC. The QAC is not described in either program description (found only in the Humana org chart). The org charts vary between the 2 program descriptions. The relationships seemed to be evolving per the minutes. Quality program activities are conducted at the market level and are the responsibility of both CareSource and Humana. Humana owns the network and retains peer review, quality of care investigations. CareSource has delegated/partnered with Beacon for BH. The above discrepancies and the Program Descriptions were discussed with the MCO during the onsite interview. The MCO reported that the 2014 description includes these committees and the reporting relationships. The QAC reporting relationship is as follows: QAC>Humana East Division QMC>Humana Corp QIC.Humana Board; ;and QAC>CareSource Q Enterprise Committee> CareSource Board	

Final Report 9/12/2014

Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
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			Recommendation for Humana CareSource Organizational charts and Program Descriptions should clearly and consistently describe the committee structure, reporting relationships and responsibilities.	
The program shall also have processes that provide for the evaluation of access to care, continuity of care, health care outcomes, and services provided or arranged for by the Contractor.		Full	Processes to evaluate access, continuity, outcomes and services are addressed throughout several documents. • 2013 Quality Improvement Program, Humana CareSource • 2014 Kentucky Market Addendum, Corporate Quality Improvement Program Description, Medicaid Managed Care Program • Humana CareSource Quality Improvement Program Annual Evaluation January 1 – December 31, 2013 • 2013 HCS QAPI Work Plan	
The Contractor's QI structures and processes shall be planned, systematic and clearly defined.		Full	Structures and processes are defined in: • 2013 Quality Improvement Program, Humana CareSource (p. 9-15) • 2014 Kentucky Market Addendum, Corporate Quality Improvement Program Description, Medicaid Managed Care Program. Page 5-13 describes the relationship between:	

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			o Humana Corporate Quality Committee o Humana East Division Quality Management Committee o Humana CareSource Quality Assessment Committee o CareSource Quality Enterprise Committee ("a delegated vendor for Quality Operations for the Kentucky Medicaid Contract") Refinement of processes between the entities is noted throughout the first year's QAC minutes.	
The Contractor's QI activities shall demonstrate the linkage of QI projects to findings from multiple quality evaluations, such as the EQR annual evaluation, opportunities for improvement identified from the annual HEDIS indicators and the consumer and provider surveys, internal surveillance and monitoring, as well as any findings identified by an accreditation body.		Full	Addressed by the Humana CareSource Quality Improvement Program Annual Evaluation January 1 – December 31, 2013. As noted, 2013 was a start-up year. Although unable to demonstrate linkage of QI activities to findings from specified evaluation sources, barrier analysis / ongoing and planned activities were based on previous experience. QAC minutes demonstrate activity around delegate/internal surveillance results: Beacon, MCNA, pharmacy, UM, grievance and appeals.	

Final Report 9/12/2014

Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
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			Discussion of the linkage of QI activities to multiple evaluation sources is found throughout: • 2013 Quality Improvement Program, Humana CareSource • 2014 Kentucky Market Addendum, Corporate Quality Improvement Program Description, Medicaid Managed Care Program. Approved 11.8.13. • 2013 HCS QAPI Work Plan	
The QAPI program shall be developed in collaboration with input from Members.		Full	Member input is addressed by: • 2013 Quality Improvement Program, Humana CareSource (p. 8) • QAC minutes – contains decision to leverage the existing Community Council to meet KAR requirements for a QMAC (Quality Member Access Committee) which is also open to community representatives and advocates for the members.	
The Contractor shall maintain documentation of all member input; response; conduct of performance improvement activities; and feedback to Members.		Full	Addressed by: • Humana – - CareSource Quality Member Access Committee Charter 2013 • QMAC minutes	
The Contractor shall have or obtain within 2-4 years and maintain National Committee for Quality Assurance		Not Applicable	Humana CareSource is not currently accredited. Accreditation is expected in	

Final Report 9/12/2014

Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
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(NCQA) accreditation for its Medicaid product line.			2016.	
The Contractor shall provide the Department a copy of its current certificate of accreditation together with a copy of the complete survey report every three years including the scoring at the category, Standard, and element levels, as well as NCQA recommendations, as presented via the NCQA Interactive Survey System (ISS): Status, Summarized & Detailed Results, Performance, Performance Measures, Must Pass Results Recommendations and History.		Not Applicable	Humana CareSource is not currently accredited. Accreditation is expected in 2016.	
Annually, the Contractor shall submit the QAPI program description document to the Department for review by July 31 of each contract year.		Substantial	Related language regarding annual update of the QI program is found in: • Humana Kentucky Market Addendum Corporate Quality Improvement Program Description o p. 12 – the EDQMC (Humana East Division Quality Management Committee) reviews and updates Market Quality Improvement Program Descriptions as indicated o p. 22 – the corporate QIPD is reviewed and updated annually • Humana CareSource Work Plan – the QAPI PD is approved annually in March Language regarding annual submission of the QIPD to the Department is not found.	Humana - CareSource believes we have been fully compliant with this contract requirement as evidenced by the submission of Report 84 on or before July 31, 2014. <u>Final Review Determination:</u> No change in compliance level. Humana-CareSource submitted the QI Program Description timely in 2014 as described, however, the period of review was CY 2013. Additionally, Humana-CareSource should include the submission of the QI Program Description to DMS by July 31st annually in its QI Work Plan as stated in the original findings and recommendation.

Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
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			Recommendation for Humana CareSource The Work Plan should include annual submission of the QIPD to the Department.	
As the Contractor will provide Behavioral Health services, the Contractor shall integrate Behavioral Health indicators into its QAPI program and include a systematic, ongoing process for monitoring, evaluating, and improving the quality and appropriateness of Behavioral Health Services provided to Members.		Minimal	Integration of BH with medical health and the QI program is described briefly in the QI Program Descriptions. The reader is referred to the partner/delegate Beacon program descriptions: • Humana Kentucky Market Addendum Corporate Quality Improvement Program Description (p. 7) • 2013 Quality Improvement Program, Humana CareSource (p. 18) The following Beacon documents address monitoring, evaluation and quality improvement: • Beacon Health Strategies 2013 Quality Management and Improvement Program Description (p. 17-21) • 2013 HCS QAPI Work Plan – Delegate Beacon (Behavioral Health) Work Plan However, BH services evaluation is not further addressed in Humana CareSource	Humana - CareSource agrees with the recommendation and will incorporate behavioral health integration, performance metrics, and analysis and actions taken to address the quality behavioral health services into its 2014 QI Program Description. These program description changes will be reviewed and approved by the HCS Quality Assessment Committee. These items will be evaluated in the 2015 QI Program Evaluation.

Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
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			documents, such as the Annual Program Evaluation (with the exception of the BH PIP).The 2014 Beacon Program Evaluation is not available for review; it is scheduled for committee review in July 2014. Evaluation of BH services was discussed during the onsite review. The MCO's subcontractor, Beacon, has a different schedule than the Contractor for completing/approving the annual program evaluation. Since this information would not be available to Humana CareSource when preparing the MCO's annual program evaluation, the MCO intends to use information obtained over the course of the year from Beacon in completing its evaluation. The QAC minutes include review and discussion of Beacon metrics on a regular basis. **Recommendation for Humana CareSource** Humana CareSource's QI Program Description and Program Evaluation should address behavioral health integration, performance metrics, and analysis and actions taken to address the quality behavioral health services.	
The Contractor shall collect data, and monitor and		Minimal	As above. Evaluation of physical health	Humana - CareSource agrees with the recommendation and

Final Report 9/12/2014

Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
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evaluate for improvements to physical health outcomes resulting from behavioral health integration into the Member's overall care.			outcomes resulting from behavioral health integration are addressed only by: • Beacon Health Strategies 2013 Quality Management and Improvement Program Description (p. 19 – diabetes monitoring, cardiovascular monitoring, functional assessment, quality of life) **Recommendation for Humana CareSource** Humana CareSource's QI Program Description and Program Evaluation should address behavioral health integration, performance metrics, and analysis and actions taken to address the quality behavioral health services.	will incorporate behavioral health integration, performance metrics, and analysis and actions taken to address the quality behavioral health services into its 2014 QI Program Description. These program description changes will be reviewed and approved by the HCS Quality Assessment Committee. These items will be evaluated in the 2015 QI Program Evaluation.
19.2 Annual QAPI Review				
The Contractor shall annually review and evaluate the overall effectiveness of the QAPI program to determine whether the program has demonstrated improvement in the quality of care and service provided to Members. The Contractor shall modify, as necessary, the QAPI Program, including Quality Improvement policies and procedures; clinical care standards; practice guidelines and patient protocols; utilization and access to Covered Services; and treatment outcomes. The Contractor shall prepare a written report to the Department, detailing the annual review and shall include a review of completed and		Full	As noted, the annual QAPI review (including policies, guidelines, utilization and outcomes) is described throughout: • 2013 Quality Improvement Program, Humana CareSource (p. 21, 37 – submission to the state) • 2013 HCS QAPI Work Plan – will be submitted to KMS August 2014 The written evaluation report (including	

Final Report 9/12/2014

Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
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continuing QI activities that address the quality of clinical care and service; trending of measures to assess performance in quality of clinical care and quality of service; any corrective actions implemented; corrective actions which are recommended or in progress; and any modifications to the program. There shall be evidence that QI activities have contributed to meaningful improvement in the quality of clinical care and quality of service, including preventive and behavioral health care, provided to Members. The Contractor shall submit this report by July 31 of each contract year.			current activities and successes, planned trending and potential modification) is addressed by: • Humana CareSource Quality Improvement Program Annual Evaluation January 1 – December 31, 2013	
21.3 External Quality Review				
The Contractor shall provide information to the EQRO as requested to fulfill the requirements of the mandatory and optional activities required in 42 CFR Parts 433 and 438.		Full	As noted by pre-onsite document review, and onsite file review, information has been made available to the EQRO. Program descriptions generally address federal, state and accreditation entities; and site visits, examinations, inquiries or investigations. • 2013 Quality Improvement Program, Humana CareSource (p. 20, 35). "All quality improvement activities are made available to Federal (CMS), State and Accreditation entities if requested." • Humana Kentucky Market Addendum Corporate Quality Improvement Program Description (p, 18) "Section X. Compliance with	

Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
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			Regulations. Humana maintains compliance with federal, state, and local regulatory bodies involved in the oversight of Managed Care Organization." "Activities may include: Participating in, and/or cooperating with site visits, examinations, inquiries, or investigations." Addressed in P/P QI- 16: QI-Cooperating with the EQRO and Incorporating Findings into the QI Plan-KY.	
The Contractor shall cooperate and participate in the EQR activities in accordance with protocols identified under 42 CFR 438, Subpart E. These protocols guide the independent external review of the quality outcomes and timeliness of, and access to, services provided by a Contractor providing Medicaid services. In an effort to avoid duplication, the Department may also use, in place of such audit, information obtained about the Contractor from a Medicare or private accreditation review in accordance with 42 CFR 438.360.		Full	Cooperation/participation in this EQRO review is noted. Addressed in P/P QI- 16: QI-Cooperating with the EQRO and Incorporating Findings into the QI Plan-KY.	
21.4 EQR Administrative Reviews				
The Contractor shall assist the Department and the EQRO in identification of Provider and Member information required to carry out annual, external independent reviews of the quality outcomes and timeliness of on-site or off-site medical chart reviews. Timely notification of		Full	Addressed in P/P QI- 16: QI-Cooperating with the EQRO and Incorporating Findings into the QI Plan-KY.	

Final Report 9/12/2014

Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
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Providers and subcontractors of any necessary medical chart review shall be the responsibility of the Contractor.				
The Contractor shall assist the EQRO in competing all Contractor reviews and evaluations in accordance with established protocols previously described.		Full	Addressed in P/P QI- 16: QI-Cooperating with the EQRO and Incorporating Findings into the QI Plan-KY.	
21.5 EQR Performance				
If during the conduct of an EQR by an EQRO acting on behalf of the Department, an adverse quality finding or deficiency is identified, the Contractor shall respond to and correct the finding or deficiency in a timely manner in accordance with guidelines established by the Department and EQRO. The Contractor shall:		Full	Humana CareSource began operations in Kentucky in 2013 with the first EQRO review occurring in 2014. Addressed in P/P QI- 16: QI-Cooperating with the EQRO and Incorporating Findings into the QI Plan-KY.	
A. Assign a staff person(s) to conduct follow-up concerning review findings;		Full	Addressed in P/P QI- 16: QI-Cooperating with the EQRO and Incorporating Findings into the QI Plan-KY.	
B. Inform the Contractor's Quality Improvement Committee of the final findings and involve the committee in the development, implementation and monitoring of the corrective action plan; and		Full	Addressed in P/P QI- 16: QI-Cooperating with the EQRO and Incorporating Findings into the QI Plan-KY. Per Care Source P/P QI-16, Humana CareSource's Quality Assurance Committee serves this role.	
C. Submit a corrective action plan in writing to the EQRO and Department within 60 days that addresses the measures the Contractor intends to take to resolve the finding. The Contractor's final resolution of all potential quality concerns shall be completed within six (6) months of the Contractor's notification.		Full	Addressed in P/P QI- 16: QI-Cooperating with the EQRO and Incorporating Findings into the QI Plan-KY.	

Final Report 9/12/2014

Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
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D. The Contractor shall demonstrate how the results of the External Quality Review (EQR) are incorporated into the Contractor's overall Quality Improvement Plan and demonstrate progressive and measurable improvement during the term of this contract; and		Full	Addressed in P/P QI- 16: QI-Cooperating with the EQRO and Incorporating Findings into the QI Plan-KY.	
E. If contractor disagrees with the EQRO's findings, it shall submit its position to the Commissioner of the Department whose decision is final.		Full	Addressed in P/P QI- 16: QI-Cooperating with the EQRO and Incorporating Findings into the QI Plan-KY.	
19.3 QAPI Plan				
The Contractor shall have a written QAPI work plan that		Full	CareSource prepares the Work Plan / Humana approves the Work Plan. Content and process are described in the following documents. • 2013 Quality Improvement Program, Humana CareSource (p. 21, 35, 37) • Humana Kentucky Market Addendum Corporate Quality Improvement Program Description (20, 22) The 2013 HCS QAPI Work Plan was submitted for review. The Work Plan includes the Beacon (Behavioral Health) work plan.	
outlines the scope of activities and		Full	The scope of activities is included in the 2013 HCS QAPI Work Plan.	
the goals,		Full	Goals are included in the 2013 HCS QAPI Work Plan.	

Final Report 9/12/2014

Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
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			Although not yet reported, the HEDIS section notes "Please reference corporate HEDIS Work Plan-KY Section," which was not found.	
objectives, and		Full	Objectives are included in the 2013 HCS QAPI Work Plan.	
timelines for the QAPI program.		Full	Timelines are included in the 2013 HCS QAPI Work Plan.	
New goals and objectives must be set at least annually based on findings from quality improvement activities and studies, survey results, Grievances and Appeals, performance measures and EQRO findings.		Full	Required sources / findings and quarterly work plan updates are included in the 2013 HCS QAPI Work Plan.	
The Contractor is accountable to the Department for the quality of care provided to Members. The Contractor's responsibilities of this include, at a minimum: approval of the overall QAPI program and annual QAPI work plan;		Full	Per the following documents, accountability is as follows: • Humana Kentucky Market Addendum Corporate Quality Improvement Program Description (6, 9-12) • 2013 Quality Improvement Program, Humana CareSource (p. 11) 1. The Market President (and CS QEC, HCS QAC) is responsible for the oversight / implementation of the quality improvement program at the local market level. 2. The East Division Director (and EDQMC)	

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			is responsible for oversight / approval of market quality improvement programs and work plans. 3. The Humana CQIC is ultimately responsible for approval of the overall QAPI program and work plan.	
designation of an accountable entity within the organization to provide direct oversight of QAPI;		Full	As above.	
review of written reports from the designated entity on a periodic basis, which shall include a description of QAPI activities, progress on objectives, and improvements made;		Full	The CS QEC submits quarterly reports to the ED QMC; the ED QMC submits quarterly reports to the CQIC. • Humana Kentucky Market Addendum Corporate Quality Improvement Program Description (p. 6) • 2013 Quality Improvement Program, Humana CareSource (p. 11)	
review on an annual basis of the QAPI program; and		Full	The HCS QAC and CQIC review the quality improvement program at least annually: • Humana Kentucky Market Addendum Corporate Quality Improvement Program Description (p. 6) • 2013 Quality Improvement Program, Humana CareSource (p. 11, 21)	
modifications to the QAPI program on an ongoing basis to accommodate review findings and issues of concern within the organization.		Full	As noted, reporting / review / follow-up and action plan development at all levels occurs at least quarterly. The work plan is	

Final Report 9/12/2014

Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
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			updated quarterly. • 2013 Quality Improvement Program, Humana CareSource (p. 20-21)	
The Contractor shall have in place an organizational Quality Improvement Committee that shall be responsible for all aspects of the QAPI program.		Full	As above. The Humana CareSource arrangement has resulted in multiple quality improvement committees: CS QEC, HCS QAC, ED QMC, CQIC.	
The committee structure shall be interdisciplinary and be made up of both providers and administrative staff. It should include a variety of medical disciplines, health professions and individual(s) with specialized knowledge and experience with Individuals with Special Health Care Needs.		Full	Interdisciplinary committee membership addressed by: • Humana Kentucky Market Addendum Corporate Quality Improvement Program Description (p. 11 – ED QMC multispecialty) • 2013 Quality Improvement Program, Humana CareSource (p. 11 – CS QEC cross-functional with subject matter experts) • 2013 Charter Humana CareSource Quality Assessment Committee • HCS QAC minutes QAC includes 3 community practitioners – currently from family practice and pediatrics. The MCO is considering expansion to include specialty providers, dental, pharmacy, other provider types. QMAC includes Commission for Children and other specialty providers as well as member representatives. QMAC reports to the QAC.	

Final Report 9/12/2014

Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
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The committee shall meet on a regular basis and activities of the committee must be documented; all committee minutes and reports shall be available to the Department upon request.		Full	Addressed for the various quality committees as follows: • Humana Kentucky Market Addendum Corporate Quality Improvement Program Description o CQIC meets monthly (p. 6) o ED QMC reports quarterly (p. 12) • 2013 Quality Improvement Program, Humana CareSource o CS QEC meets quarterly and maintains minutes (p. 11) • 2013 Charter Humana CareSource Quality Assessment Committee o HCS QAC meets quarterly and maintains minutes, which were provided for this review.	
QAPI activities of Providers and Subcontractors, if separate from the Contractor's QAPI activities, shall be integrated into the overall QAPI program. Requirements to participate in QAPI activities, including submission of complete Encounter Records, are incorporated into all Provider and Subcontractor contracts and employment agreements. The Contractor's QAPI program shall provide feedback to the Providers and Subcontractors regarding integration of, operation of, and corrective actions necessary in Provider and Subcontractor QAPI activities.		Full	2013 HCS QAPI Work plan includes Beacon and MCNA as delegated entities. The Beacon, MCNA, and provider contracts were provided for review. All requirements were addressed by: • Master Services Agreement by and between CareSource Management Group Co. and Beacon Health Strategies LLC • Master Services Agreement by and between CareSource Management	

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			Group Co. and Managed Care of North America dba MCNA Dental Plans • ChoiceCare Network Participation Agreements amendment for providers participation with Kentucky Medicaid HMO network • Humana Network Participation Agreements amendment for providers participation with Kentucky Medicaid HMO product	
The Contractor shall integrate other management activities such as Utilization Management, Risk Management, Member Services, Grievances and Appeals, Provider Credentialing, and Provider Services in its QAPI program.		Full	A multidisciplinary program integrating all business units is addressed by: • 2013 Quality Improvement Program, Humana CareSource (p. 7, 11-15) • Humana Kentucky Market Addendum Corporate Quality Improvement Program Description (p. 6, 16) • HCS QAC minutes	
Qualifications, staffing levels and available resources must be sufficient to meet the goals and objectives of the QAPI program and related QAPI activities. Such activities include, but are not limited to, monitoring and evaluation of Member's care and services, including those with special health care needs, use of preventive services, coordination of behavioral and physical health care needs, monitoring and providing feedback on provider performance, involving members in QAPI initiatives and conducting performance improvement projects. Written		Substantial	Resources, staffing and qualifications are addressed by: • 2013 Quality Improvement Program, Humana CareSource o Executive and director-level staff (p. 15-17) o Enterprise-wide staff participation (p. 21) • Humana Kentucky Market Addendum Corporate Quality	Humana - CareSource agrees with the recommendation and will include the language regarding submission of information (FTE's, and percentage of time dedicated to QAPI) to KDMS upon request into the 2014 QI Program Description. These program description changes will be reviewed and approved by the HCS Quality Assessment Committee.

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documentation listing staffing resources, including total FTE's, percentage of time, experience, and roles shall be submitted to the Department upon request.			Improvement Program Description o Quality Operations Compliance and Accreditation Department o Additional individuals from listed departments (p. 16-17) The Program Description does not include language regarding submission of information (FTE's and percentage of time dedicated to QAPI) to the Department upon request. Required activities are addressed by: • 2013 Quality Improvement Program, Humana CareSource (p. 8-9, 34-35) • Humana Kentucky Market Addendum Corporate Quality Improvement Program Description (p. 20-21) **Recommendation for Humana CareSource** The Program Description should include reporting of staffing resources to the Department upon request.	
19.4 QAPI Monitoring and Evaluation				
A. The Contractor, through the QAPI program, shall monitor and evaluate the quality of clinical care on an ongoing basis. Health care needs such as acute or chronic physical or behavioral conditions, high volume,		Minimal	All healthcare need indicators, evaluation and uses are described throughout the program descriptions and are presented in the program evaluation :	Humana - CareSource agrees with the recommendation and will incorporate behavioral health integration, performance metrics, and analysis and actions taken to address the quality

Final Report 9/12/2014

Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
and high risk, special needs populations, preventive care, and behavioral health shall be studied and prioritized for performance measurement, performance improvement and/or development of practice guidelines. Standardized quality indicators shall be used to assess improvement, assure achievement of at least minimum performance levels, monitor adherence to guidelines and identify patterns of over- and under-utilization. The measurement of quality indicators selected by the Contractor must be supported by valid data collection and analysis methods and shall be used to improve clinical care and services.			• 2013 Quality Improvement Program, Humana CareSource (p. 17, 34 – validity) • Humana CareSource Quality Improvement Program Annual Evaluation January 1 – December 31, 2013 As noted in 19.1, HCS began serving members in January of 2013 and the ability to measure the overall effectiveness of the QI Program lags. Empty table shells for 2013 and 2014 measurement were provided, as were barriers based on experience, activities and plans. Also noted in 19.1, information regarding Behavioral Health monitoring, evaluation and improvement are provided by: • Beacon Health Strategies 2013 Quality Management and Improvement Program Description • 2013 HCS QAPI Work Plan – Delegate Beacon (Behavioral Health) work plan BH services evaluation was not addressed in the Humana CareSource Program Evaluation as noted above.	behavioral health services into its 2014 QI Program Description. These program description changes will be reviewed and approved by the HCS Quality Assessment Committee. These items will be evaluated in the 2015 QI Program Evaluation.

Final Report 9/12/2014

Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			Recommendation for Humana CareSource Humana CareSource's QI Program Description and Program Evaluation should address behavioral health integration, performance metrics, and analysis and actions taken to address the quality behavioral health services.	
B. Providers shall be measured against practice guidelines and standards adopted by the Quality Improvement Committee.		Full	Monitoring adherence to practice guidelines is addressed by: • 2013 Quality Improvement Program, Humana CareSource (p. 17, 30-31) • Quality Improvement - Development and Distribution of Preventive Health and Clinical Practice Guidelines for Care Policy (p. 3) • 2013 Performance Measures Summary – medical record review to be conducted 3rd and 4th quarter 2014 Population-based and practice-based assessment is described, with HEDIS results where applicable. Several panned HEDIS measurements, based on guideline use, were presented in: • Humana CareSource Quality Improvement Program Annual Evaluation January 1 – December 31, 2013	

Final Report 9/12/2014

Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Areas identified for improvement shall be tracked and corrective actions taken as indicated.		Full	Escalating intervention is used: • 2013 Quality Improvement Program, Humana CareSource (p. 30)	
The effectiveness of corrective actions must be monitored until problem resolution occurs. The Contractor shall perform reevaluations to assure that improvement is sustained.		Full	As above. Medical record review is ongoing: • 2013 Quality Improvement Program, Humana CareSource (p. 31)	
C. The Contractor shall use appropriate multidisciplinary teams to analyze and address data or systems issues.		Full	Cross-functional teams are addressed throughout, but specifically by: • 2013 Quality Improvement Program, Humana CareSource (p. 21, 37) • Humana Kentucky Market Addendum Corporate Quality Improvement Program Description (p. 11 – ED QMC) • HCS QAC minutes	
D. The Contractor shall submit to the Department upon request documentation regarding quality and performance improvement (QAPI) projects/performance improvement projects (PIPs) and assessment that relates to enrolled members.		Full	Submission to the state of all projects is addressed by: • 2013 Quality Improvement Program, Humana CareSource (p. 35) • Humana Kentucky Market Addendum Corporate Quality Improvement Program Description (p. 18)	
E. The Contractor shall develop or adopt practice guidelines that are disseminated to Providers and to Members upon request.		Full	Guideline dissemination is addressed by: • Quality Improvement - Development and Distribution of Preventive Health and Clinical Practice	

Final Report 9/12/2014

Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			Guidelines for Care Policy (p. 2)	
The guidelines shall be based on valid and reliable medical evidence or consensus of health professionals;		Full	Guideline sources are addressed by: • Quality Improvement - Development and Distribution of Preventive Health and Clinical Practice Guidelines for Care Policy (p. 2)	
consider the needs of Members;		Full	Guideline topics are identified through analysis of enrolled membership: • Quality Improvement - Development and Distribution of Preventive Health and Clinical Practice Guidelines for Care Policy (p. 2)	
developed or adopted in consultation with contracting health professionals, and		Full	Inclusion of board-certified practitioners from appropriate specialties is addressed by: • Quality Improvement - Development and Distribution of Preventive Health and Clinical Practice Guidelines for Care Policy (p. 2)	
reviewed and updated periodically.		Full	Guidelines are reviewed and updated at least every two years: • Quality Improvement - Development and Distribution of Preventive Health and Clinical Practice Guidelines for Care Policy (p. 2)	
Decisions with respect to UM, member education, covered services, and other areas to which the practice guidelines apply shall be consistent with the guidelines.		Full	Consistency with guidelines is addressed by: • Quality Improvement - Development	

Final Report 9/12/2014

Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			and Distribution of Preventive Health and Clinical Practice Guidelines for Care Policy (p. 4) Monitoring consistent application of guidelines is addressed by: • 2013 Performance Measures Summary – medical record review to be conducted 3rd and 4th quarter 2014	
19.5 Innovative Programs				
Contractor shall implement its innovative program as presented in the response to the RFP and report quarterly on its program to improve and reform the management of the pharmacy program as contained in the Contractor's response to the RFP.		Full	Innovative program implementation (and reporting) addressed by: • Innovative Program Description and Status Update – Babies First Program Humana CareSource provided documents and reports related to the Medication Therapy Management (MTM) program. The MTM program is a collaborative project that includes Humana CareSource; its subcontractor, Outcomes MTM; and community pharmacists. The program includes an annual Complete Medication Review that allows members to meet one-on-one with a pharmacist to review their complete medication profile to detect and prevent conflicts or duplications. iConnect is another innovative program	

Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			implemented by Humana CareSource that allows members to communicate ideas and provide feedback to the MCO on its programs and services. Members choose their method of communication – text, email, or social media. Approximately 130 members have joined iConnect.	
20.1 Kentucky Outcomes Measures and HEDIS Measures				
The Contractor shall implement steps targeted at improvement for selected performance measures, identified in Appendix O, in either the actual outcomes or processes used to affect those outcomes. Once performance goals are met, select measures may be retired and new measures, based on CMS guidelines and/or developed collaboratively with the Contractor, may be implemented, if either federal or state priorities change; findings and/or recommendations from the EQRO; or identification of quality concerns; or findings related to calculation and implementation of the measures require amended or different performance measures, the parties agree to amend the previously identified measures.		Full	KY-specific performance measures addressed by: • 2013 Quality Improvement Program, Humana CareSource (p. 21-28) • 2013 Performance Measures Summary – Healthy Kentuckians Outcomes Measure Report currently being compiled for 2013	
Additionally, the Department, Contractor, and EQRO will review and evaluate the feasibility and strategy for rotation of measures requiring hybrid or medical record data collection to reduce the burden of measure production. The group may consider the annual HEDIS measure rotation schedule as part of this process.		Full	KY-specific performance measures addressed by: • 2013 Quality Improvement Program, Humana CareSource (p. 21-28) • 2013 Performance Measures Summary – Healthy Kentuckians Outcomes Measure Report currently	

Final Report 9/12/2014

Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			being compiled for 2013	
The Contractor in collaboration with the Department and the EQRO shall develop and initiate a performance measure specific to ISHCN.		Full	Primary care source, annual physical exam, and biannual dental exam for children with SHCN was addressed by: • 2013 Quality Improvement Program, Humana CareSource (p. 27-28)	
The Department shall assess the Contractor's achievement of performance improvement related to the health outcome measures. The Contractor shall be expected to achieve demonstrable and sustained improvement for each measure.		Not Applicable	HEDIS 2014 will be available June 2014 and will provide baseline data.	
Specific quantitative performance targets and goals are to be set by the workgroup. The Contractor shall report activities on the performance measures in the QAPI work plan quarterly and shall submit an annual report after collection of performance data. The Contractor shall stratify the data to each measure by the Medicaid eligibility category, race, ethnicity, gender and age to the extent such information has been provided by the Department to the Contractor. This information will be used to determine disparities in health care.		Substantial	The 2013 HCS QAPI Work Plan contained quarterly updates. Planned stratification was not evident in these documents. **<u>Recommendation for Humana CareSource</u>** The QAPI Work Plan should include plans for stratification of performance data and analysis of this data.	Humana-CareSource believes we have been fully compliant with this contract requirement as evidenced by quarterly updates to the work plan and the planned submission of Attachment A (state specific measures) due to IPRO on 9/5/14. <u>Final Review Determination:</u> No change in compliance level. Humana Care-Source was compliant with the requirement to submit quarterly reports of performance measures to DMS. However, Humana-CareSource was not compliant with the requirement to stratify performance measure data by Medicaid eligibility category, race, ethnicity, gender and age. Although the MCO did not have performance measure data in 2013, plans to stratify the data, when available, should have been reflected in the QI Work Plan.

Final Report 9/12/2014

Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
20.2 HEDIS Performance Measures				
The Contractor shall be required to collect and report HEDIS data annually. After completion of the Contractor's annual HEDIS data collection, reporting and performance measure audit, the Contractor shall submit to the Department the Final Auditor's Report issued by the NCQA certified audit organization and an electronic (preferred) or printed copy of the interactive data submission system tool (formerly the Data Submission tool) by no later than August 31st.		Full	Submission of Final Auditor's Report is addressed by: • 2013 Quality Improvement Program, Humana CareSource (p. 35) • 2013 HCS Work Plan – HEDIS entry: HEDIS will be conducted in 2014. Please reference corporate HEDIS Work Plan-KY Section (not seen). • 2013 Performance Measures Summary – by August 31 via Report 96	
In addition, for each measure being reported, the Contractor shall provide trending of the results from all previous years in chart and table format. Where applicable, benchmark data and performance goals established for the reporting year shall be indicated. The Contractor shall include the values for the denominator and numerator used to calculate the measures.		Full	The 2013 HCS QI Program Evaluation was submitted with table templates due to reporting lags. Templates displayed year-to-year trending. In areas where measurement was possible (calls, grievances, appeals) numerators and denominators were often displayed.	
For all reportable Effectiveness of Care and Access/Availability of Care measures, the Contractor shall stratify each measure by Medicaid eligibility category, race, ethnicity, gender and age.		Substantial	The 2013 HCS QI Program Evaluation was submitted with table templates due to reporting lags. Planned stratification was not addressed in this document. **<u>Recommendation for Humana</u>**	Humana-CareSource believes we have been fully compliant with this contract requirement as evidenced by quarterly updates to the work plan and the planned submission of Report 96 due to KDMS on 8/31/14. <u>Final Review Determination:</u> No change in compliance level.

Final Report 9/12/2014

Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			CareSource The QI Program Evaluation should include stratification of performance data and analysis of this data.	Humana Care-Source was compliant with the requirement to submit quarterly reports of performance measures to DMS. However, Humana-CareSource was not compliant with the requirement to stratify HEDIS data by Medicaid eligibility category, race, ethnicity, gender and age. Although the MCO did not have performance measure data in 2013, plans to stratify the data, when available, should have been reflected in the QI Work Plan.
Annually, the Contractor and the Department will select a subset of targeted performance from the HEDIS reported measures on which the Department will evaluate the Contractor's performance. The Department shall inform the Contractor of its performance on each measure, whether the Contractor satisfied the goal established by the Department, and whether the Contractor shall be required to implement a performance improvement initiative. The Contractor shall have sixty (60) days to review and respond to the Department's performance report.		Not Applicable	To date, DMS has not chosen a subset of measures for evaluation. Annually DMS, in collaboration with the EQRO, evaluates the measures required for reporting.	
The Department reserves the right to evaluate the Contractor's performance on targeted measures based on the Contractor's submitted encounter data. The Contractor shall have 60 days to review and respond to findings reported as a result of these activities.		Not Applicable	To date, DMS has not chosen a subset of measures for evaluation using MCO submitted encounter data.	
20.3 Accreditation of Contractor by National Accrediting Body				
A Contractor which holds current NCQA accreditation		Not Applicable	Humana is not currently NCQA accredited	

Final Report 9/12/2014

Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
status shall submit a copy of its current certificate of accreditation with a copy of the complete accreditation survey report, including scoring of each category, standard, and element levels, and recommendations, as presented via the NCQA Interactive Survey System (ISS): Status. Summarized & Detailed Results, Performance, Performance Measures, Must Pass Results Recommendations and History to the Department in accordance with timelines established by the Department.			in Kentucky. NCQA accreditation of the Humana Medicaid program in Florida and the Humana CareSource plan is noted. Work toward becoming accredited in Kentucky is addressed by the 2013 Quality Improvement Program, Humana CareSource (p. 6).	
If a Contractor has not earned accreditation of its Medicaid product through the National Committee for Quality Assurance (NCQA) Health Plan, the MCO shall be required to obtain such accreditation within two (2) to four (4) years from the effective date of this contract.		Full	Required accreditation within 2 – 4 years is addressed by 2014 Kentucky Market Addendum, Corporate Quality Improvement Program Description, Medicaid Managed Care Program (p. 18).	
20.4 Performance Improvement Projects (PIPs)				
The Contractor must ensure that the chosen topic areas for PIPs are not limited to only recurring, easily measured subsets of the health care needs of its Members. The selected PIPs topics must consider: the prevalence of a condition in the enrolled population; the need(s) for a specific service(s); member demographic characteristic and health risks; and the interest of Members in the aspect of care/services to be addressed.		Full	PIP topic considerations are addressed by: • 2013 HCS QI Program Evaluation (p. 24) • 2013 HCS QAPI Work Plan	
The Contractor shall continuously monitor its own performance on a variety of dimensions of care and services for Members, identify areas for potential improvement, carry out individual PIPs, undertake system interventions to improve care and services, and		Full	PIPs may be developed around clinical and service issues requiring a coordinated and concerted effort for resolution. PIPs are included in the work plan and program evaluation:	

Final Report 9/12/2014

Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
monitor the effectiveness of those interventions. The Contractor shall develop and implement PIPs to address aspects of clinical care and non-clinical services and are expected to have a positive effect on health outcomes and member satisfaction. While undertaking a PIP, no specific payments shall be made directly or indirectly to a provider or provider group as an inducement to reduce or limit medically necessary services furnished to a Member. Clinical PIPs should address preventive and chronic healthcare needs of Members, including the Member population as a whole and subpopulations, including, but not limited to, Medicaid eligibility category, type of disability or special health care need, race, ethnicity, gender and age. PIPs shall also address the specific clinical needs that have a higher prevalence in the enrolled population. Non-clinical PIPs should address improving the quality, availability and accessibility of services provided by the Contractor to members and providers. Such aspects of service should include, but not be limited to, availability, accessibility, cultural competency of services, and complaints, grievances, and appeals.			• 2013 Quality Improvement Program, Humana CareSource (p. 20, 35) • 2013 HCS QAPI Work Plan (clinical PIPS noted) • 2013 HCS QI Program Evaluation (clinical PIPS and ongoing CAPHS QIP noted) General prohibitions on incentives to limit care are found in: • Humana CareSource Provider Manual (p. 81) • Beacon Humana CareSource Provider Manual (p. 19)	
The Contractor shall develop collaborative relationships with local health departments, behavioral health agencies and other community based health/social agencies to achieve improvements in priority areas. Linkage between the Contractor and public health agencies is an essential element for the achievement of public health objectives.		Full	Collaborative relationships with BH and community-based organizations is noted in: • 2013 HCS QI Program Evaluation (America n Diabetes Association (ADA), American Lung Association (ALA), National Alliance for the Mentally Ill (NAMI), Community Mental Health Centers (CMHC))	

Final Report 9/12/2014

Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			• Humana - CareSource Quality Member Access Committee Charter 2013 and minutes • Beacon Health Strategies 2013 Quality Management and Improvement Program Description (p. 3, 21 – state agencies)	
The Department and the Contractor shall be committed to on-going collaboration in the area of service and clinical care improvements by the development of best practices and use of encounter data–driven performance measures.		Not Applicable	As 2013 is the MCO's first year of operations, development of best practices and use of encounter-data driven performance measures is not applicable. Performance measure reporting is scheduled for June 2014. **Recommendation for Humana CareSource** Language regarding the development of best practices should be included in the 2014 Program Description.	Humana-CareSource agree the Quality Improvement Program Purpose content, and Alignment with the CMS Quality Strategy language which addresses best practices and performance measures will be included in the KY QIPD MCD addendum with next version update.
The Contractor shall monitor and evaluate the quality of care and services by initiating a minimum of two (2) PIPs each year, including one relating to physical health and one relating to behavioral health. However, the Contractor may propose an alternative topic(s) for its annual PIPs to meet the unique needs of its Members if the proposal and justification for the alternative(s) are submitted to and approved by the Department. Additionally, the Department may require Contractor to (i) implement an additional PIP specific to the Contractor; if findings from an EQR review or audit indicate the need		Full	Humana CareSource will conduct annually, one medical and one behavioral health PIP: • 2014 Kentucky Market Addendum, Corporate Quality Improvement Program Description, Medicaid Managed Care Program (p. 20) Compliance with clinical studies and collection of indicator data as required by State, Federal or other regulatory agencies	

Final Report 9/12/2014

Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
for a PIP, or if directed by CMS; and (2) assist the Department in one annual statewide PIP, if requested. In assisting the Department with implementation of an annual statewide PIP, the Contractor's participation shall be limited to providing the Department with readily available data from the Contractor's region. The Contractor shall submit reports on PIPs as specified by the Department.			addressed by: • 2013 Quality Improvement Program, Humana CareSource (p. 34) PIP report submission to the EQR and Department addressed by: • 2013 HCS QAPI Work Plan • 2013 HCS QI Program Evaluation (p. 24-25)	
The Department has identified four clinical areas and non-clinical topics for PIPs as a baseline assessment of Medicaid members in Appendix N.		Full	Two PIP proposals were submitted : 1. To reduce the incidence of major depression that is untreated with antidepressant medication therapy 2. Emergency Department Use Management	
The Contractor shall report on each PIP utilizing the template provided by the Department and must address all of the following in order for the Department to evaluate the reliability and validity of the data and the conclusions drawn:		Full	As above.	
A. Topic and its importance to enrolled members;		Full	Addressed in each PIP proposal.	
B. Methodology for topic selection;		Full	Addressed in each PIP proposal.	
C. Goals;		Full	Addressed in each PIP proposal. • In addition to outcome goals, several process measurements and goals are included in each proposal.	

Final Report 9/12/2014

Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
D. Data sources/collection;		Full	Addressed in each PIP proposal. • Barrier assessment / process measurement include several data sources.	
E. Intervention(s) – not required for projects to establish baseline; and		Not Applicable	Addressed in each PIP proposal. Interventions are to be developed beginning 1/1/14. Planned interventions extend through 12/31/15. Collaboration with Beacon is noted.	
F. Results and interpretations – clearly state whether performance goals were met, and if not met, analysis of the intervention and a plan for future action.		Not Applicable	Baseline measurement 12/31/13, 1st re-measurement 12/31/14 and 2nd re-measurement 12/31/15.	
The final report shall also answer the following questions and provide information on:				
A. Was Member confidentiality protected;		Not Applicable	Confidentiality is addressed in each PIP proposal. Final reports are not due.	
B. Did Members participate in the performance improvement project?		Not Applicable	Members are engaged in each PIP proposal. Final reports are not due.	
C. Did the performance improvement project include cost/benefit analysis or other consideration of financial impact;		Not Applicable	Final reports are not due. However, it is noted that ED use management proposal noted savings attributable to Triage Nurse Line during preliminary measurement Jan-June 2013.	
D. Were the results and conclusions made available to members, providers and any other interested bodies;		Not Applicable	Final reports are not due.	

Final Report 9/12/2014

Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
E. Is there an executive summary;		Not Applicable	Final reports are not due.	
F. Do illustrations – graphs, figures, tables – convey information clearly.		Not Applicable	Final reports are not due.	
Performance reporting shall utilize standardized indicators appropriate to the performance improvement area. Minimum performance levels shall be specified for each performance improvement area, using standards derived from regional or national norms or from norms established by an appropriate practice organization. The norms and/or goals shall be predetermined at the commencement of each performance improvement goal and the Contractor shall be monitored for achievement of demonstrable and/or sustained improvement		Full	Addressed by each PIP proposal: • Baseline measurement serves as minimum performance level for each PIP proposal. • Pre-determined goals are described as percentage improvement over baseline.	
The Contractor shall validate if improvements were sustained through periodic audits of the relevant data and maintenance of the interventions that resulted in improvement. The timeframes for reporting:		Full	Addressed by 2013 HCS QI Program Evaluation (p. 24-25).	
A. Project Proposal – due September 1 of each contract year. If PIP identified as a result of Department/EQRO review, the project proposal shall be due sixty (60) days after notification of requirement.		Full	Proposal submitted to KDMS 3/27/13 and to IPRO and KDMS 12/8/13: • 2013 HCS QAPI Work plan	
B. Baseline Measurement – due at a maximum, one calendar year after the project proposal and no later than September 1 of the contract year.		Full	Addressed by 2013 HCS QAPI Work plan.	
C. 1st Remeasurement – no more than two calendar years after baseline measurement and no later than		Full	Addressed by 2013 HCS QAPI Work plan.	

Final Report 9/12/2014

Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
September 1 of the contract year.				
D. 2nd Remeasurement – no more than one calendar year after the first remeasurement and no later than September 1 of the contract year.		Full	Addressed by 2013 HCS QAPI Work plan.	
20.5 Quality and Member Access Committee				
The Contractor shall establish and maintain an ongoing Quality and Member Access Committee (QMAC) composed of Members, individuals from consumer advocacy groups or the community who represent the interests of the Member population.		Full	Addressed by: • Humana – CareSource Quality Member Access Committee Charter 2013 • HCS QMAC /Consumer Council minutes	
Members of the Committee shall be consistent with the composition of the Member population, including such factors as aid category, gender, geographic distribution, parents, as well as adult members and representation of racial and ethnic minority groups. Responsibilities of the Committee shall include:		Full	Addressed by: • Humana – CareSource Quality Member Access Committee Charter 2013 • HCS QMAC /Consumer Council minutes	
A. Providing review and comment on quality and access standards;		Full	Addressed by: • Humana – CareSource Quality Member Access Committee Charter 2013 • HCS QMAC /Consumer Council minutes	
B. Providing review and comment on the Grievance and Appeals process as well as policy modifications needed based on review of aggregate Grievance and Appeals data;		Full	Addressed by: • Humana – CareSource Quality Member Access Committee Charter 2013	

Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			• HCS QMAC /Consumer Council minutes	
C. Review and provide comment on Member Handbooks;		Full	Addressed by: • Humana – CareSource Quality Member Access Committee Charter 2013 • HCS QMAC /Consumer Council minutes	
D. Reviewing Member education materials prepared by the Contractor;		Full	Addressed by: • Humana – CareSource Quality Member Access Committee Charter 2013 • HCS QMAC /Consumer Council minutes	
E. Recommending community outreach activities; and		Full	Addressed by: • Humana – CareSource Quality Member Access Committee Charter 2013 • HCS QMAC /Consumer Council minutes	
F. Providing reviews of and comments on Contractor and Department policies that affect Members.		Full	Addressed by: • Humana – CareSource Quality Member Access Committee Charter 2013 • HCS QMAC /Consumer Council minutes	
The list of the Members participating with the QMAC shall be submitted to the Department annually.		Full	Addressed by: • Humana – CareSource Quality	

Final Report 9/12/2014

Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			Member Access Committee Charter 2013 • HCS QMAC /Consumer Council minutes	
20.8 Assessment of Member and Provider Satisfaction and Access				
The Contractor shall conduct an annual survey of Members' and Providers' satisfaction with the quality of services provided and their degree of access to services. The member satisfaction survey requirement shall be satisfied by the Contractor participating in the Agency for Health Research and Quality's (AHRQ) current Consumer Assessment of Healthcare Providers and Systems survey ("CAHPS") for Medicaid Adults and Children, administered by an NCQA certified survey vendor.		Full	Addressed by: • 2013 Quality Improvement Program, Humana CareSource (p. 35-36) • 2014 Kentucky Market Addendum, Corporate Quality Improvement Program Description, Medicaid Managed Care Program (p. 12, 21 – oversight by ED QMC) • 2013 HCS QI Program Evaluation o p. 17 – provider o p. 21 – member • 2013 HCS QAPI Work Plan o Provider Satisfaction Survey is being conducted by the Myers Groups, 1st qtr. 2014 o Member Satisfaction Survey will be performed by the Myers Group in early 2014	
The Contractor shall provide a copy of the current CAHPS survey tool to the Department.		Not Applicable	Surveys will be conducted by the Meyers Group in early 2014.	
Annually, the Contractor shall assess the need for conducting special surveys to support quality/performance improvement initiatives that target		Full	The MCO is conducting a BH survey and a case management (CM) survey, both through Myers Group. The case	

Final Report 9/12/2014

Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
subpopulations perspective and experience with access, treatment and services.			management survey includes members that were active in CM in 2013 and assesses member satisfaction with the CM process; goals met and improvement in care.	
To meet the provider satisfaction survey requirement the Contractor shall submit to the Department for review and approval the Contractor's current provider satisfaction survey tool.		Not Applicable	Surveys will be conducted by the Meyers Group in early 2014.	
The Department shall review and approve any Member and Provider survey instruments and shall provide a written response to the Contractor within fifteen (15) days of receipt.				
The Contractor shall provide the Department a copy of all survey results. A description of the methodology to be used in conducting the Provider or other special surveys, the number and percentage of the Providers or Members to be surveyed, response rates and a sample survey instrument, shall be submitted to the Department along with the findings and interventions conducted or planned.		Not Applicable	Surveys will be conducted by the Meyers Group in early 2014.	
All survey results must be reported to the Department, and upon request, disclosed to Members.		Not Applicable	Surveys will be conducted by the Meyers Group in early 2014. **Recommendation for Humana CareSource** Language regarding disclosure to members should be included in the 2014 Program Description.	Humana-CareSource information on survey disclosure to members will be included in the KY QIPD MCD addendum with next version update.

Final Report 9/12/2014

Quality Assessment and Performance Improvement: Measurement and Improvement *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.236, 438.240)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
37.5 QAPI Reporting Requirements The Contractor shall provide status reports of the QAPI program and work plan to the Department on a quarterly basis thirty (30) working days after the end of the quarter and as required under this section and upon request. All reports shall be submitted in electronic and paper format.		Substantial	Language regarding submission of quarterly status reports to the Department (and submission format) is not found. Quarterly submission of reports (e.g., reports, high-level variance reports, and status reports) internally is noted throughout: • 2013 Quality Improvement Program, Humana CareSource • 2014 Kentucky Market Addendum, Corporate Quality Improvement Program Description, Medicaid Managed Care Program **Recommendation for Humana CareSource** The QI Program Description and Work Plan should include quarterly reporting to the Department.	Humana - CareSource believes we have been fully compliant with this contract requirement as evidenced by quarterly submissions to KDMS of Report #16, 17, & 18. Humana - CareSource believes we have been fully compliant with this contract requirement as evidenced by the submission of Report 84 on or before July 31, 2014. Final Review Determination: No change in compliance level. Humana-CareSource submitted the quarterly reports of the QAPI Program and Work Plan as described, however, Humana-CareSource should include the submission of these quarterly reports to DMS in its QI Program Description and QI Work Plan as stated in the original findings and recommendation.
Reference the following documents for further information: **Appendix K** **Appendix N** **Appendix O**				

Final Report 9/12/2014

Quality Assessment and Performance Improvement: Measurement and Improvement

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	77	6	3	0
Total Points	231	12	3	0

Overall Compliance Determination:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Range	**3.0**	**2.0 – 2.99**	**1.0 – 1.99**	**0 – 0.99**
Points Average		**2.86**		

As part of the review IPRO assessed the MCO's implementation of any actions proposed by the MCO in response to last year's findings. It should be noted that deficiencies previously identified that continue to be deficient in the current review, may adversely affect the scoring of a requirement.

Reviewer Decision:

Full Compliance	MCO has met or exceeded requirements
Substantial Compliance	MCO has met most requirements but may be deficient in a small number of areas
Minimal Compliance	MCO has met some requirements but has significant deficiencies requiring corrective action
Non- Compliance	MCO has not met the requirements
Not Applicable (NA)	Statement does not require a review decision; for reviewer information purposes

Shading of Review Determination Column Only=Not subject to review, e.g., header, DMS responsibility
Shading of Columns for Review Determination, Comments and Health Plan's and DMS's Responses and Plan of Action=Not subject to review for the current review year, e.g., standard deemed due to full compliance achieved during prior review

Final Report 9/12/2014

Quality Assessment and Performance Improvement: Measurement and Improvement
Suggested Evidence

Documents

QI Program Description
QI Work Plan
Evidence of member involvement in development of QI program
Annual PIP proposals and summary reports
Quality Improvement Committee description, membership, meeting agendas and minutes
Committee description, membership, meeting agendas and minutes for QMAC
Clinical Practice Guidelines
Provider Manual
Provider Newsletters
Provider Committee minutes
Innovative Program description and status report

Reports

Annual QI Evaluation Report
HEDIS Final Audit Report and IDSS rates
Healthy Kentuckians Outcomes Measures Report
CAHPS Report
Provider Satisfaction Survey Report
NCQA Accreditation Certificate and ISS Survey Report or status of accreditation
Performance Measure Reporting
Evaluation, analysis and follow-up of performance measure results
Evaluation, analysis and follow-up of provider compliance with Clinical Practice Guidelines
Monitoring of consistent application of practice guidelines for utilization management, enrollee education, and coverage of service

KY EQRO ANNUAL REVIEW
March 2014
Period of Review: January 1, 2013 – December 31, 2013
MCO: Humana CareSource

Final Report 9/5/2014

Grievance System *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
24. General Requirements for Grievances and Appeals			**General Recommendation for Humana CareSource:** Policies, procedures, reports and documents should be consistent with regard to branding/MCO name and specific to Kentucky Medicaid. The full MCO name, Humana CareSource, should be used consistently.	Humana-CareSource is in the process of reviewing policies, procedures, reports, and documents to ensure branding consistency with the "Humana-CareSource" name and logo. Additionally, we are reviewing all policies and procedures to ensure they are Kentucky Medicaid specific.
The Contractor shall have a grievance system in place for Members that includes a grievance process related to "dissatisfaction" and an appeals process related to a Contractor "action," including the opportunity to request a State fair hearing pursuant to KRS Chapter 13B.		Full	Humana has a corporate and CareSource KY plan grievance, appeal and State Hearing system in place which includes policies detailing the system processes. The Member Handbook, New Member Kit, Statement of Member Rights and Responsibilities – Kentucky and Newsletters are used to communicate these policies and procedures to members, and a Provider Manual to communicate to providers. The relevant policies are: 1. SO – 20: Service Operations – Member Grievance – Kentucky. Purpose: To define the grievance system CareSource has in place for members. 2. QM-KY-011-00: CareSource Potential Quality of Care Issues-Submission to Humana. Purpose: To define the process for referral and management to Quality Operations Compliance and Accreditation of potential quality of care complaints (grievances) of Kentucky Medicaid members for services rendered by Humana network provider. 3. QI-01: Quality Improvement - Clinical Appeal of Member and Provider Pre Service/ Post Service Denials and Expedited Appeals. Purpose: To maintain a formal appeal process for the denial of member and provider pre and post clinical services, as well as	

Final Report 9/5/2014

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
			expedited appeals. 4. SO- 19 Service Operations – Member Appeal Kentucky. Purpose: To ensure timely and appropriate resolution of verbal and written member expedited appeals. 5. QM-295-00: Referrals for Quality of Care from Non-Humana Associates. Purpose: To define the process for external entities to refer potential quality of care cases or member complaints to the Humana Quality Operations Compliance and Accreditation (QOCA) Department. 6. SO-22: Service Operations – Statement of Member Rights and Responsibilities – Kentucky. Purpose: To ensure CareSource members are informed about their rights and responsibilities as consumers. 7. EN-30: Enrollment – New Member Kits and ID Cards. Purpose: To provide specific plan information to members upon enrollment. 8. OI-19: Quality Improvement - State Hearing Procedure Policy – Kentucky. Purpose: To define and document the Kentucky State Hearing procedure.	
The Contractor shall implement written policies and procedures describing how the Member may submit a request for a grievance or an appeal with the Contractor or submit a request for a state fair hearing with the State. The policy shall include a description of how the Contractor resolves the grievance or appeal.		Full	Addressed in the following P/Ps: SO – 20: Service Operations – Member Grievance – Kentucky. QI-01: Quality Improvement - Clinical Appeal of Member and Provider Pre Service/ Post Service Denials and Expedited Appeals. OI-19: Quality Improvement - State Hearing Procedure Policy – Kentucky.	

Final Report 9/5/2014

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
			These policies are communicated to members in the 2013 Member Handbook: pg. 1 has toll-free number for filing an appeal or grievance, pg. 40 has process for filing a grievance, pg. 41 has process for filling an appeal, and pg. 42 has process for requesting a state hearing. Also communicated in New Member Kits as stated in Policy Number (EN-30).	
The Contractor shall provide to all Providers in the Contractor's network a written description of its grievance and appeal process and how providers can submit a grievance or appeal for a Member or on their own behalf.		Full	Addressed in the following P/Ps: SO – 20: Service Operations – Member Grievance – Kentucky. QI-01: Quality Improvement - Clinical Appeal of Member and Provider Pre Service/ Post Service Denials and Expedited Appeals. CL-08: Provider Claim Appeal: Ohio and Kentucky. These policies are communicated to providers in the 2013 Provider Manual Kentucky Medicaid as follows: How to Submit a Provider Grievance or Appeal pg. 65, Member Grievance, Appeals, and Fair Hearing Requests pg.66-67 (pg. 67 states: There are three ways to submit appeals: through our Provider Portal, by fax or in writing), and Network Pharmacy Appeals pgs.68-69.	
The Contractor shall make available reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.		Full	The assistance available to help members file a grievance is described in the Member Handbook which includes a toll-free Member Services phone number (TTY), email and mailing addresses, and a copy of the optional form that members may use to file a grievance with Humana CareSource.	

Final Report 9/5/2014

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
			The assistance available to help members file an appeal is described in the Member Handbook and includes a toll-free Member Services phone number (TTY), email and mailing addresses, and a copy of the optional form that members may use to file an appeal with Humana CareSource. The assistance available to help members request a state fair hearing is described in the Member Handbook and includes a toll-free State Medicaid Program phone number (TTY), FAX number, and mailing address. A toll-free number and mailing address are also provided for the KY Ombudsman. The Member Newsletter, Fall 2013 documents the availability of assistance with interpreters and TTY/TTD for non-English speaking members.	
The Contractor shall name a specific individual(s) designated as the Contractor's Medicaid Member grievances or appeals coordinator with the authority to administer the policies and procedures for resolution of a grievance or appeal, to review patterns/trends in grievances or appeals, and to initiate corrective action.		Full	Humana CareSource has a manager in place to serve this function.	
The Contractor shall ensure that the individuals who make decisions on grievances or appeals are not involved in any previous level of review or decision-making. The Contractor shall also ensure that health care professionals with appropriate clinical expertise shall make decisions for the		Full	Addressed for grievances in Policy Number (SO – 20), Service Operations – Member Grievance Kentucky, which states: "Individuals that make decisions on grievances are individuals who: b. Were not involved in previous levels of review or	

Final Report 9/5/2014

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
following:			decision-making. c. If required, are healthcare professionals having appropriate clinical expertise treating the member's condition or disease if deciding any of the following: i. A grievance regarding the denial of an expedited resolution of an appeal. ii. A grievance involving clinical issues." Addressed for appeals in Policy Number (QI-01): Quality Improvement –"Clinical Appeal of Member and Provider Pre Service/ Post Service Denials and Expedited Appeal, which states: Clinical appeal considerations are conducted by health professionals who: i. Are clinical peers; v. Are in the same profession and in a similar specialty as typically manages the medical condition, procedure or treatment as mutually deemed appropriate; and vi. Are neither the individual who made the original non-certification, nor the subordinate of such an individual."	
A. An appeal of a Contractor denial that is based on lack of medical necessity;		Full	Addressed for appeals in Policy Number (QI-01).	
B. A Contractor denial that is upheld in an expedited resolution; and		Full	Addressed for grievances in Policy Number (SO – 20) and for appeals in Policy Number (QI-01).	
C. A grievance or appeal that involves clinical issues.		Full	Addressed for grievances in Policy Number (SO – 20) and for appeals in Policy Number (QI-01).	
The Contractor shall provide Members, separately or as a part of the Member handbook, information on how they or their		Full	Addressed as stated above in Section 24, on availability of assistance. The Member Handbook pg. 42 states:	

Final Report 9/5/2014

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
representative(s) can file a grievance or an appeal, and the resolution process. The Member information shall also advise Members of their right to file a request for a state fair hearing with the Cabinet, upon notification of a Contractor action, or concurrent with, subsequent to or in lieu of an appeal of the Contractor action.			You must ask for a hearing within 30 days from the date on our appeal decision letter.	
The Contractor shall ensure that punitive or retaliatory action is not taken against a Member or service provider that files a grievance or an appeal, or a provider that supports a Member's grievance or appeal.		Substantial	For grievances addressed in Policy Number (SO – 20): Service Operations – Member Grievance – Kentucky which states: "CareSource will ensure that no punitive or retaliatory action is taken against a member or service provider that files a grievance or appeal or a provider that supports a Member's grievance." For appeals addressed in Policy Number (SO-19) Service Operations – Member Appeal Kentucky which states: "Neither members, their authorized representatives nor providers filling appeals on behalf of members will be subject to punitive or retaliatory actions as the result of exercising their grievance and appeal rights." Communicated to members in the Member Handbook on pg 42 which states: "…punitive or retaliatory action will not be taken against: a Member or service provider that files a grievance or an appeal; or a provider that supports a Member's grievance or appeal." Evidence of communication of this policy to providers was not evident in the documentation provided.	Humana-CareSource agrees with this recommendation. Language will be added to the Provider Manual.

Final Report 9/5/2014

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
			Recommendation for Humana CareSource: This policy should be communicated to providers in the Provider Manual or provider agreement.	
24.1 Grievance Process				
A grievance is an expression of dissatisfaction about any matter or aspect of the Contractor or its operation, other than a Contractor action as defined in this contract.				
A Member may file a grievance either orally or in writing with the Contractor within thirty (30) calendar days of the date of the event causing the dissatisfaction. The legal guardian of the Member for a minor or an incapacitated adult, a representative of the Member as designated in writing to the Contractor, or a service provider acting on behalf of the Member and with the Member's written consent, have the right to file a grievance on behalf of the Member.		Full	Addressed in Policy Number (SO – 20) Service Operations – Member Grievance – Kentucky, which states: "Grievances may be filed verbally or in writing within 30 calendar days of the date of the event causing the dissatisfaction. A member, the legal guardian of the member for a minor or an incapacitated adult, a representative of the member as designated in writing to CareSource, or service provider acting on behalf of the member and with the member's written consent, have the right to file a grievance on behalf of the member. Written consent is not required on behalf of a member under the age of 18 years or when the individual filing the grievance is an authorized member representative." Communicated to members in the Member Handbook.	
Within five (5) working days of receipt of the grievance, the Contractor shall provide the grievant with written notice that the grievance has been received and the expected date of its resolution.		Full	Addressed in SO-20. Communicated to members in the Member Handbook. Grievance File Review	

Final Report 9/5/2014

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
			A total of 20 member grievance files were reviewed (10 quality-related grievances and 10 random grievances). Acknowledgement letters were issued timely. In some cases an acknowledgment letter was not necessary as the grievance was resolved and the member notified in less than 5 days of receipt of the grievance.	
The investigation and final Contractor resolution process for grievances shall be completed within thirty (30) calendar days of the date the grievance is received by the Contractor and shall include a resolution letter to the grievant.		Full	Addressed in SO-20. Communicated to members in the Member Handbook. <u>Grievance File Review</u> 20/20 files reviewed were resolved timely.	
The Contractor may extend by of up to fourteen (14) calendar days if the Member requests the extension, or the Contractor determines that there is need for additional information and the extension is in the Member's interest. For any extension not requested by the Member, the Contractor shall give the Member written notice of the reason for the extension within two working days of the decision to extend the timeframe.		Non Compliance	Not Addressed in SO-20. Per MCO, MCO contract with DMS does not include this requirement. Upon review of the document "Final Humana Contract for Region 3 (3).docx" and confirmation with DMS, it was determined that the contract does contain this requirement: contract section 24.1 Grievance Process and section 24.2 Appeal Process each state: "The Contractor may extend by of up to fourteen (14) calendar days if the Member requests the extension, or the Contractor determines that there is need for additional information and the extension is in the Member's interest. For any extension not requested by the Member, the Contractor shall give the Member written notice of the reason for the extension within two working days of the decision to extend the timeframe."	Humana-CareSource agrees that the 2013 MCO contract language was not in the Policy SO-20. However, this language is not included in the 2014 contracts between KDMS and Humana. Therefore, Humana-CareSource does not see the need to add the above language to its P/P SO-20 and ensure that written notification within 2 days is provided to the member in the case of an extension for grievance resolution not requested by the member.

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
			Recommendation for Humana CareSource: HCS should add the above language to its P/P SO-20 and ensure that written notification within 2 days is provided to the member in the case of an extension for grievance resolution not requested by the member.	
Upon resolution of the grievance, the Contractor shall mail a resolution letter to the Member. This resolution letter may not take the place of the acknowledgment letter referred to in Section B above, unless the resolution of the grievance has been completed and can be communicated to the Member in the same correspondence acknowledging receipt of the grievance. The resolution letter shall include, but not be limited to, the following:		Full	Addressed in SO-20.	During the onsite file review, QI staff presented details of the investigation and closure for each of the files via the QMS system. None of the files resulted in a confirmed quality concern. Humana CareSource believes that it has a clear process on how we identify, classify, and investigate member concerns. However, after the audit Humana CareSource reviewed the Policy and Procedures associated with this review and implemented enhancements to include a review process to ensure that a member's complaint is thoroughly reviewed. It is Humana-CareSource's policy to not disclose details of the investigation and resolution of a member grievance against a provider. However, upon reviewing the template grievance letter Humana CareSource agrees to review the letters and consider providing some detail, especially if there is an opportunity to educate or provide clarification to the member.
A. All information considered in investigating the grievance;		Substantial	Addressed in SO-20. Member Grievance File Review-Quality 10/10 files did not include information on the	Addressed in SO-20 MCO Response Section

Final Report 9/5/2014

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section	Health Plan's and DMS' Responses and Plan of Action
			investigation. This information is maintained separately by the QI department on the QMS system. During the onsite file review, QI staff presented details of the investigation and closure for each of the files via the QMS system. None of the files resulted in a confirmed quality concern. Two cases appeared to require further follow-up. In one case, the member was not aware of test results or why blood work and medications were needed. In this case, the MCO could have contacted the provider and requested that the provider discuss the testing and medications with the member. In another case, the case was classified as an attitude concern and no records were requested or reviewed. This case did appear to be a medical concern rather than an attitude concern. The MCO stated that this case would be re-opened. The resolution notices to members contain generic language and do not provide details regarding the investigation or outcome – "This letter is dealing with your recent complaint. An investigation has been completed dealing with your concerns. Your complaint was reviewed by a skilled health care expert. We cannot report the exact actions taken. We have to keep these steps private. We can tell you that your complaint was completely reviewed. Proper action was taken. Thank you for your input. Input from Members improves our quality. Humana CareSource is committed to giving Members the best quality care."	

Final Report 9/5/2014

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
			Member Grievance File Review-Random 10 files were reviewed. Two issues were identified. In one file, the file and resolution notice indicate that the complaint regarding rudeness of a representative would be investigated however there is no evidence in the file that this was done or a referral made to the relevant department. In another file, a member requested disenrollment and was verbally provided with the phone number for KY Medicaid. However, in the written notice, the section for the phone number was not completed. **Recommendation for Humana Care Source** The MCO should ensure that all concerns presented by the member are addressed and that concerns are appropriately classified and investigated. Humana CareSource should consider providing some details in the resolution notice when there is an opportunity to educate a member or provide clarification.	
B. Findings and conclusions based on the investigation; and		Substantial	Addressed in SO-20. Member Grievance File Review See above.	Addressed in SO-20 MCO Response Section
C. The disposition of the grievance.		Substantial	Addressed in SO-20. Member Grievance File Review	Addressed in SO-20 MCO Response Section

Final Report 9/5/2014

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
			See above.	
24.2 Appeal Process				
An appeal is a request for review by the Contractor of a Contractor action.				
A. An action for purpose of an appeal is:				
(1) the denial or limited authorization of a requested services, including the type or level of service;		Full	Addressed in Policy Number (QI-01): Quality Improvement - Clinical Appeal of Member and Provider Pre Service/ Post Service Denials and Expedited Appeals.	
(2) the reduction, suspension, or termination of a previously authorized service;		Full	Addressed in QI-01.	
(3) the denial, in whole or in part, of payment for a service;		Full	Addressed in QI-01.	
(4) the failure of the Contractor to provide services in a timely manner, as defined by the Department or its designee; or		Full	Addressed in QI-01.	
(5) the failure of the Contractor to complete the authorization request in a timely manner as defined in 42 CFR 438.408.		Full	Addressed in QI-01.	
(6) for a resident of a rural area with only one Contractor, the denial of a Member's request to exercise his or her right under 42 CFR 438.52(b)(2)(ii) to obtain services outside the network.		Full	Addressed in QI-01.	
B. The Contractor shall mail a notice of action to the Member or service provider. The notice shall comply with 42 CFR 438.10(c) regarding language and (d) regarding format and		Substantial	Addressed in (SO-19) Service Operations – Member Appeal – Kentucky. Addressed in the Member Handbook.	

Final Report 9/5/2014

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
shall contain, but not be limited to, the following:			UM File Review 10 files were reviewed. See file results below under subcomponents.	
(1) the action the Contractor has taken or intends to take;		Full	Addressed in (SO-19) and Member Handbook. UM File Review 10/10 files were compliant.	
(2) the reasons for the action;		Full	Addressed in (SO-19) and Member Handbook. UM File Review 10/10 files were compliant.	
(3) the Member's or the service provider's right, as applicable, to file an appeal of the Contractor action through the Contractor;		Full	Addressed in (SO-19) and Member Handbook. UM File Review 10/10 files were compliant.	
(4) the Member's right to request a state fair hearing and what the process would be;		Minimal	Addressed in (SO-19) and Member Handbook. UM File Review 10/10 files did not show evidence of member's right to a State Fair Hearing included in the resolution notice. Humana advised during the onsite review that the member must exhaust the internal appeal process before requesting a State hearing. **Recommendation for Humana Care Source** The adverse determination notice should include reference to the member's right to a State hearing if	Humana-CareSource disagrees with this determination. Humana CareSource understands that a member must exhaust his/her appeal rights before requesting a state fair hearing. Currently, the initial denial letter contains information on filing an appeal, and the appeal upheld letter contains information on filing a state fair hearing. Originally, the letters contained information about both the appeal and the state fair hearing but it caused member confusion so the extraneous information was deleted. We think this is the most accurate and least confusing way to explain to

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
			the member requests an appeal and the appeal upholds the initial decision. This requirement was confirmed with DMS.	members their rights and asks IPRO and the state to let our letters continue to include only the next step in the appeal process. Final Review Determination: No change in compliance level. It is correct that the member must exhaust the MCO appeal rights before requesting a state hearing. However, it was confirmed with DMS that at at the time of initial denial, the MCOs must disclose the member's right to a SFH after exhausting the appeal rights. This can be communicated in one simple sentence. The entire SFH process need not be described.
(5) the procedures for exercising the rights specified;		Full	Addressed in (SO-19) and the Member Handbook. UM File Review 10/10 files addressed procedures for exercising the right to appeal.	
(6) the circumstances under which expedited resolution of an appeal is available and how to request it; and		Full	Addressed in (SO-19) and Member Handbook. UM File Review 10/10 files were compliant.	
(7) the Member's right to have benefits continue pending resolution of an appeal or state fair hearing, how to request the continuation of benefits, and the circumstances under which the Member may be required to pay the costs of continuing these benefits.		Substantial	Addressed in (SO-19) and Member Handbook. UM File Review 10/10 files were compliant for continuation of benefits pending an appeal. Fair hearing language is not	Humana-CareSource disagrees with this determination. It is Humana CareSource's understanding that a member must exhaust his/her appeal rights before requesting a state fair hearing. Currently, the initial denial letter contains information on filing an appeal, and the appeal upheld letter

Final Report 9/5/2014

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
			included in the adverse action notice. **Recommendation for Humana CareSource** Notices should include the required language regarding continuation of benefits pending a State hearing: "…the right to have benefits continue pending resolution of an appeal or state fair hearing, how to request the continuation of benefits, and the circumstances under which the Member may be required to pay the costs of continuing these benefits."	contains information on filing a state fair hearing. Originally, the letters contained information about both the appeal and the state fair hearing but it caused member confusion so the extraneous information was deleted. We think this is the most accurate and least confusing way to explain to members their rights and asks IPRO and the state to let our letters continue to include only the next step in the appeal process. Final Review Determination: No change in compliance level. It is correct that the member must exhaust the MCO appeal rig state hearing. However, it was confirmed with DMS that at at th the MCOs must disclose the member's right to a SFH after exha rights. This can be communicated in one simple sentence. The e not be described.
The notice shall be mailed within ten (10) days of the date of the action for previously authorized services as permitted under 42 CFR 431.213 and 431.214, and within fourteen (14) days of the date of the action for newly requested services. Denials of Claims that may result in Member financial liability require immediate notification.		Full	Addressed in (SO-19).	
C. A Member may file an appeal either orally or in writing of a Contractor action within thirty (30) calendar days of receiving the Contractor's notice of action. The legal guardian of the Member for a minor or an incapacitated adult, a representative of the Member as designated in writing to the Contractor, or a provider acting on behalf of the Member with the Member's written consent, have the right to file an		Full	Addressed in (SO-19) and Member Handbook.	

Final Report 9/5/2014

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
appeal of an action on behalf of the Member. The Contractor shall consider the Member, representative, or estate representative of a deceased Member as parties to the appeal.				
D. The Contractor has thirty (30) calendar days from the date the initial oral or written appeal is received by the Contractor to resolve the appeal. The Contractor shall appoint at least one person to review the appeal who was not involved in the initial decision and who is not the subordinate of any person involved in the initial decision.		Full	Addressed in QI-01. <u>Member Appeal File Review</u> A total of 12 files were reviewed. 12/12 files were timely and compliant.	
E. The Contractor shall have a process in place that ensures that an oral or written inquiry from a Member seeking to appeal an action is treated as an appeal (to establish the earliest possible filing date for the appeal). An oral appeal shall be followed by a written appeal that is signed by the Member within ten (10) calendar days. The Contractor shall use its best efforts to assist Members as needed with the written appeal and may continue to process the appeal.		Full	Addressed in QI-01. Communicated to members in the Member Handbook.	
F. Within five working days of receipt of the appeal, the Contractor shall provide the grievant with written notice that the appeal has been received and the expected date of its resolution. The Contractor shall confirm in writing receipt of oral appeals, unless the Member or the service provider requests an expedited resolution.		Full	Addressed in Policy SO-20. Communicated to members in the Member Handbook. <u>Member Appeal File Review</u> 12/12 files included an acknowledgement notice.	
G. The Contractor may extend the thirty (30) day timeframe by fourteen (14) calendar days if the Member requests the extension, or the Contractor determines that there is need for additional information, and the extension is in the Member's		Substantial	Addressed in SO-19 however the policy does not state that the notice of extension will be mailed within two working days of the decision to extend the timeframe for regular/non expedited appeals only for expedited	Humana-CareSource agrees with this recommendation. We will include the following language "…shall give the Member writte extension and the reason for the extension within two working days of the de

Final Report 9/5/2014

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
interest. For any extension not requested by the Member, the Contractor shall give the Member written notice of the extension and the reason for the extension within two working days of the decision to extend the timeframe.			appeals. Member Appeal File Review None of the files reviewed required an extension. **Recommendation for Humana CareSource** The policy should include the required language regarding written notice within 2 working days for extensions not requested by the member: "…shall give the Member written notice of the extension and the reason for the extension within two working days of the decision to extend the timeframe."	the timeframe.
H. The Contractor shall provide the Member or the Member's representative a reasonable opportunity to present evidence of the facts or law, in person as well as in writing.		Full	Addressed in QI-01. Communicated to members in the Member Handbook. Member Appeal File Review 12/12 files were compliant.	
I. The Contractor shall provide the Member or the representative the opportunity, before and during the appeals process, to examine the Member's case file, including medical or clinical records (subject to HIPAA requirements), and any other documents and records considered during the appeals process. The Contractor shall include as parties to the appeal the Member and his or her representative, or the legal representative of a deceased Member's estate.		Substantial	Addressed in SO-19 which states: "CareSource shall provide the Member or the representative the opportunity, before and during the appeals process, to examine the Member's case file, including medical or clinical records (subject to HIPAA requirements), and any other documents and records considered during the appeals process. CareSoursce shall include as parties to the appeal any individuals referenced in Section 3 of this policy." P/P QI-01 also addresses this requirement generally, but does not address all the specific elements of the	Humana-CareSource agrees with this recommendation. We will include all required elements of the requirement for member access to - This right is available during the appeal process - The member representative has the right to access records - That parties to the appeal include the Member and his or her r legal representative of a deceased Member's estate.

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
			requirement: "For clinical appeal upheld determinations, the organization issues written notification of the appeal decision to the member, the member's physician and/or other ordering provider or facility rendering service that includes: Notification that the member can obtain, upon request, reasonable access to and copies of all documents, including a copy of the clinical criteria/guideline, as relevant to the appeal decision was based" P/P QI-01 does not specify that: - This right is available during the appeal process - The member representative has the right to access records - That parties to the appeal include the Member and his or her representative, or the legal representative of a deceased Member's estate. <u>Member Appeal File Review</u> 12/12 files were compliant. **<u>Recommendation for Humana CareSource</u>** The MCO should revise policy QI-01 to include all required elements of the requirement for member access to appeal records: - This right is available during the appeal process - The member representative has the right to access records - That parties to the appeal include the Member	

Final Report 9/5/2014

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
			and his or her representative, or the legal representative of a deceased Member's estate.	
J. For all appeals, the Contractor shall provide written notice within the thirty (30) calendar-day timeframe for resolutions to the Member or the provider, if the provider filed the appeal. The written notice of the appeal resolution shall include, but not be limited to, the following information:		Substantial	Addressed in SO-19 which states: "For all appeals, CareSource shall provide written notice within the 3 (policy states 3 not 30) calendar-day timeframe for resolutions to the Member or the provider, if the provider filed the appeal." Member Appeal File Review 12/12 files were compliant. **Recommendation for Humana CareSource** The MCO should correct the apparent typographical error in the written notice timeframe (3 versus 30 days).	Humana-CareSource agrees with this recommendation. The apparent typographical error in the written notice timeframe (3 versus 30 days) will be corrected.
(1) the results and reasoning behind the appeal resolution; and		Full	Addressed in SO-19. Member Appeal File Review 12/12 files were compliant.	
(2) the date it was completed.		Full	Addressed in SO-19. Member Appeal File Review 12/12 files were compliant.	
K. The written notice of the appeal resolution for appeals not resolved wholly in favor of the Member shall include, but not be limited to, the following information:		Substantial	Addressed in QI-01. Member Appeal File Review	Humana-CareSource agrees with this recommendation. Resolut updated to include the possibility of member liability for the cost of cont

Final Report 9/5/2014

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
			See subcomponents below.	fair hearing finds in favor of the plan.
(1) the right to request a state fair hearing and how to do so;		Full	Addressed in QI-01 and communicated to members in the Handbook. Member Appeal File Review 12/12 files were compliant.	
(2) the right to request receipt of benefits while the state fair hearing is pending, and how to make the request; and		Full	Addressed in SO-19 and communicated to members in the Handbook. Member Appeal File Review 12/12 files were compliant.	
(3) that the Member may be held liable for the cost of continuing benefits if the state fair hearing decision upholds the Contractor's action.		Minimal	Addressed in SO-19 and communicated to members in the Member Handbook. Member Appeal File Review Files did not address member liability. **Recommendation for Humana CareSource** Resolution notice should include the possibility of member liability for the cost of continuing benefits if the fair hearing finds in favor of the plan.	Humana-CareSource agrees with this recommendation. Resolution notices will be updated to include the possibility of member liability for the cost of continuing benefits if the fair hearing finds in favor of the plan.
L. The Contractor shall continue the Member's benefits if all of the following are met:		Full	Addressed in QI-01 and communicated to members in the Handbook.	
(1) the Member or the service provider files a timely appeal of the Contractor action or the Member asks for a state fair hearing within 30 days from the date on the Contractor notice		Full	Addressed in QI-01.	

Final Report 9/5/2014

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
of action;				
(2) the appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;		Full	Addressed in QI-01 and communicated to members in the Handbook.	
(3) the services were ordered by an authorized service provider;		Full	Addressed in QI-01 and communicated to members in the Handbook.	
(4) the time period covered by the original authorization has not expired; and		Full	Addressed in QI-01 and communicated to members in the Handbook.	
(5) the Member requests extension of the benefits.		Full	Addressed in QI-01 and communicated to members in the Handbook.	
M. The Contractor shall provide benefits until one of the following occurs:				
(1) The Member withdraws the appeal;		Full	Addressed in QI-01.	
(2) Fourteen (14) days have passed since the date of the resolution letter, provided the resolution of the appeal was against the Member and the Member has not requested a state fair hearing or taken any further action;		Non-compliance	QI-01, on page 5 item h(ii): the MCO will provide benefits until 10 days have passed following Humana CareSource mailing the notice of an adverse appeal decision to the member. The P/P refers to Ohio instead of Kentucky and states 10 days instead of 14 days **Recommendation for Humana Care Source** In general, the combination of OH and KY requirements in the single P/P is confusing and as noted, sometimes incomplete related to KY requirements. Humana CareSource should establish a KY-specific P/P for this and other MCO procedures and processes. The policy should include Kentucky-specific requirement of 14 days after mailing.	Humana-CareSource agrees with this recommendation. A Humana-CareSource specific appeals policy will be written to address only KY requirements including the Kentucky-specific requirement of 14 days after mailing.

Final Report 9/5/2014

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
(3) The Cabinet issues a state fair hearing decision adverse to the Member;		Non-compliance	Addressed in QI-01 however the policy refers to Ohio instead of Kentucky on page 5 items h(ii) and h(iii). Discussion of KY statutes or KY fair hearing is not included. **Recommendation for Humana Care Source** In general, the combination of OH and KY requirements in the single P/P is confusing and as noted, sometimes incomplete related to KY requirements. Humana CareSource should establish a KY-specific P/P for this and other MCO procedures and processes. The policy should include the Kentucky-specific requirement, "the Cabinet issues a state fair hearing decision adverse to the Member;"	Humana-CareSource agrees with this recommendation. A Humana-CareSource specific appeals policy will be written to address only KY requirements including the Kentucky-specific requirements around state fair hearings.
(4) The time period or service limits of a previously authorized service has expired.		Full	Addressed in QI-01.	
N. If the final resolution of the appeal is adverse to the Member, that is, the Contractor's action is upheld, the Contractor may recover the cost of the services furnished to the Member while the appeal was pending, to the extent that services were furnished solely because of the requirements of this section and in accordance with the policy in 42 CFR 431.230(b).		Non-compliance	Addressed in QI-01 but refers to Ohio and OH-specific requirements only, not Kentucky on page 5 item j. **Recommendation for Humana CareSource** In general, the combination of OH and KY requirements in the single P/P is confusing and as noted, sometimes incomplete related to KY requirements. Humana CareSource should establish a KY-specific P/P for this and other MCO procedures and	Humana-CareSource agrees with this recommendation. A Huma appeals policy will be written to address only KY requirements i Kentucky-specific requirement, " the Contractor may recover th furnished to the Member while the appeal was pending, to the were furnished solely because of the requirements of this section an the policy in 42 CFR 431.230(b)."

Final Report 9/5/2014

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
			processes. The policy should include the Kentucky-specific requirement, " the Contractor may recover the cost of the services furnished to the Member while the appeal was pending, to the extent that services were furnished solely because of the requirements of this section and in accordance with the policy in 42 CFR 431.230(b)."	
O. If the Contractor or the Cabinet reverses a decision to deny, limit, or delay services, and these services were not furnished while the appeal was pending, the Contractor shall authorize or provide the disputed services promptly and as expeditiously as the Member's health condition requires. If the Contractor or the Cabinet reverses a decision to deny, limit or delay services and the Member received the disputed services while the appeal was pending, the Contractor shall pay for these services.		Full	Addressed in QI-01, pg.6.	
24.3 Expedited Resolution of Appeals				
An expedited resolution of an appeal is an expedited review by the Contractor of a Contractor action.				
A. The Contractor shall establish and maintain an expedited review process for appeals when the Contractor determines that allowing the time for a standard resolution could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function. Such a determination is based on:		Full	Addressed in Policy Number SO-19 and Policy Number QI-01. Communicated to members in the Member Handbook. <u>Member Appeal File Review</u> None of the files reviewed required an expedited resolution.	

Final Report 9/5/2014

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
(1) a request from the Member;		Full	Addressed in Policy Number SO-19 and Policy Number QI-01.	
(2) a provider's support of the Member's request;		Full	Addressed in Policy Number SO-19 and Policy Number QI-01.	
(3) a provider's request on behalf of the Member; or		Full	Addressed in Policy Number SO-19 and Policy Number QI-01.	
(4) the Contractor's independent determination.		Full	Addressed in Policy Number SO-19 and Policy Number QI-01.	
The Contractor shall ensure that the expedited review process is convenient and efficient for the Member.		Full	Addressed in Policy Number SO-19.	
B. The Contractor shall resolve the appeal within three working days of receipt of the request for an expedited appeal. In addition to written resolution notice, the Contractor shall also make reasonable efforts to provide and document oral notice.		Full	Addressed in Policy Number SO-19.	
C. The Contractor may extend the timeframe by up to fourteen (14) calendar days if the Member requests the extension, or the Contractor demonstrates to the Department that there is need for additional information and the extension is in the Member's interest. For any extension not requested by the Member, the Contractor shall give the Member written notice of the reason for the delay.		Full	Addressed in Policy Number SO-19.	
E. The Contractor shall ensure that punitive action is not taken against a Member or a service provider who requests an expedited resolution or supports a Member's expedited appeal.		Full	Addressed in Policy Number SO-19. Communicated to members in the Member Handbook.	

Final Report 9/5/2014

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
F. The Contractor shall provide an expedited resolution, if the request meets the definition of an expedited appeal, in response to an oral or written request from the Member or service provider on behalf of the Member.		Full	Addressed in Policy Number SO-19.	
G. The Contractor shall inform the Member of the limited time available to present evidence and allegations in fact or law.		Full	Addressed in Policy Number SO-19. <u>Member Appeal File Review</u> None of the files reviewed required an expedited resolution.	
H. If the Contractor denies a request for an expedited resolution of an appeal, it shall:				
(1) transfer the appeal to the thirty (30) day timeframe for standard resolution, in which the thirty (30) day period begins on the date the Contractor received the original request for appeal; and		Full	Addressed in Policy Number SO-19.	
(2) make reasonable efforts to give the Member prompt oral notice of the denial, and follow up with a written notice within two-calendar days.		Full	Addressed in Policy Number SO-19.	
I. The Contractor shall document in writing all oral requests for expedited resolution and shall maintain the documentation in the case file.		Full	Addressed in Policy Number SO-19.	
24.4 State Hearings for Members				
A Member may request a State Fair Hearing if he or she is dissatisfied with an Action that has been taken by the Contractor, within thirty (30) days of receiving notice of the Action or within thirty (30) days of the final decision by the		Full	Addressed in Policy Number (QI-01) and Policy Number (QI-19). Communicated to members in the Member Handbook.	

Final Report 9/5/2014

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
Contractor.				
All documents supporting the Contractor's Action must be received by the Department no later than five (5) days from the date the Contractor receives notice from the Department that a State Fair Hearing has been filed. These records shall be made available to the Member upon request by either the Member or the Member's legal counsel. The Department will provide the Member with a hearing process that shall adhere to 907 KAR 1:563, 42 CFR 438 Subpart F and 42 CFR 431 Subpart E.		Full	Addressed in Policy Number (QI-19).	
Failure of the Contractor to comply with the State Fair Hearing requirements of the state and federal Medicaid law in regard to an Action taken by the Contractor or to appear and present evidence will result in an automatic ruling in favor of the Member.		Non-Compliance	Not Addressed in Policy Number QI-19 or other documents provided. **Recommendation for Humana** Requirement should be addressed in a policy/procedure.	Humana-CareSource agrees with this recommendation. The policy will be updated to include the following language, "Failure of the Contractor to comply with the State Fair Hearing requirements of the state and federal Medicaid law in regard to an Action taken by the Contractor or to appear and present evidence will result in an automatic ruling in favor of the Member".
27.8 Provider Grievances and Appeals				
The Contractor shall establish and maintain written policies and procedures for the filing of Provider grievances and appeals. A provider shall have the right to file a grievance or an appeal with the Contractor. Provider grievances or appeals shall be resolved within thirty (30) calendar days. If the grievance or appeal is not resolved within thirty (30) days, the Contractor shall request a fourteen (14) day extension from the provider. If the Provider requests the extension, the extension shall be approved by the Contractor. A Provider may not file a grievance or an appeal on behalf of a Member		Full	Addressed in Policy Number CL-08 Claims – Provider Claim Appeal: Ohio and Kentucky. Addressed in Policy Number QI-01. Communicated to providers in the Provider Manual, pg. 48-50. Provider Grievance and Appeals Files 10/10 grievance files and 10/10 appeal files were compliant.	

Final Report 9/5/2014

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
without written designation by the Member as the Member's representative. A Provider shall have the right to file an appeal with the Contractor regarding provider payment or contractual issues.				
27. 9 Other Related Processes				
The Contractor shall provide information specified in 42 CFR 438.10(g)(1) about the grievance system to all service providers and subcontractors at the time they enter into a contract.		Full	Policy Number (QI-01): Quality Improvement - Clinical Appeal of Member and Provider Pre Service/ Post Service Denials and Expedited Appeals as detailed in prior sections. Policy Number: CL-08 Claims – Provider Claim Appeal: Ohio and Kentucky. Policy Purpose: "To define the process the providers use to submit claim appeals to Care Source." Appeals are logged in an electronic tracking system and reviewed for consideration within 30 calendar days of receipt. Specific to Kentucky a letter of Acknowledgement is sent out to the provider when an appeal is received. The Provider Manual Section 5.1, pgs. 48-50 detail Provider Appeals and Grievance Procedures, Member Grievance, Appeals, and Fair Hearings Requests. Addressed in subcontractor agreements.	
All grievance or appeal files shall be maintained in a secure and designated area and be accessible to the Department or its designee, upon request, for review. Grievance or appeal files shall be retained for ten (10) years following the final decision by the Contractor, HSD, an administrative law judge,		Full	Addressed in SO- 19.	

Final Report 9/5/2014

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
judicial appeal, or closure of a file, whichever occurs later.				
The Contractor shall have procedures for assuring that files contain sufficient information to identify the grievance or appeal, the date it was received, the nature of the grievance or appeal, notice to the Member of receipt of the grievance or appeal, all correspondence between the Contractor and the Member, the date the grievance or appeal is resolved, the resolution, the notices of final decision to the Member, and all other pertinent information.		Substantial	Addressed in SO- 19 Service Operations – Member Appeal Kentucky, "All grievance and appeal files include, at a minimum: Member Name, Member ID, Reason for grievance or appeal, all supporting Documentation, Required Resolution and Member right to file an appeal or request a State Fair Hearing." The policy does not address: notice to the Member of receipt of the grievance or appeal, all correspondence between the Contractor and the Member, the date the grievance or appeal is resolved, the notices of final decision to the Member. Addressed in QI-01: "CareSource will maintain a record for each clinical appeal that includes: i. The name of the patient, provider and/or the facility rendering service; ii. Copies of all correspondence from the patient, provider, or facility rendering service including all documents regarding the clinical appeal that were utilized in the investigation of the appeal including any aspects of the clinical care involved; iii. Dates of clinical appeal reviews, documentation of actions taken, and final resolutions; and iv. Name and credentials of the clinical peer v. The clinical appeals case will be documented in the electronic documentation system. Policy does not explicitly state: notice to the Member of receipt of the	Humana-CareSource agrees with this recommendation. Policie consistent and to address all the requirements of the standard.

Final Report 9/5/2014

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section**	**Health Plan's and DMS' Responses and Plan of Action**
			grievance or appeal." **Recommendation for Humana Care Source** Policies should be revised to be consistent and to address all the requirements of the standard.	
Documentation regarding the grievance shall be made available to the Member, if requested.		Substantial	Not addressed in Policy Number SO – 20: Service Operations – Member Grievance – Kentucky: "The records will be made available upon request to the Commonwealth or its designee. Policy does not address availability for members." Availability of documentation related to appeals is explicitly addressed in Policy Number QI-01 Quality Improvement - Clinical Appeal of Member and Provider Pre Service/ Post Service Denials and Expedited Appeals: "Notification that the member can obtain, upon request, reasonable access to and copies of all documents, including a copy of the clinical criteria/guideline, as relevant to the appeal decision was based." Addressed in SO-19 which states: "CareSource shall provide the Member or the representative the opportunity, before and during the appeals process, to examine the Member's case file, including medical or clinical records (subject to HIPAA requirements), and any other documents and records considered during the appeals process. CareSoursce shall include as parties to the appeal any individuals referenced in Section 3 of this policy."	Humana-CareSource agrees with the recommendation. Policy will be updated to reflect the availability of documentation in the file to members upon requests for grievances.

Final Report 9/5/2014

Grievance System (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section	Health Plan's and DMS' Responses and Plan of Action
			Recommendation for Humana CareSource The P/Ps should be consistent and address availability of documentation in the file to members for grievances.	

KY EQRO ANNUAL REVIEW
March 2014
Period of Review: January 1, 2013 – December 31, 2013
MCO: Humana CareSource

Final Report 9/5/2014

Grievance System

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	63	12	2	5
Total Points	189	24	2	0

Overall Compliance Determination:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Range	**3.0**	**2.0 – 2.99**	**1.0 – 1.99**	**0 – 0.99**
Points Average		**2.62**		

As part of the review IPRO assessed the MCO's implementation of any actions proposed by the MCO in response to last year's findings. It should be noted that deficiencies previously identified that continue to be deficient in the current review may adversely affect the scoring of a requirement.

Reviewer Decision:

Full Compliance	MCO has met or exceeded requirements
Substantial Compliance	MCO has met most requirements but may be deficient in a small number of areas
Minimal Compliance	MCO has met some requirements but has significant deficiencies requiring corrective action
Non-Compliance	MCO has not met the requirements
Not Applicable (NA)	Statement does not require a review decision; for reviewer information purposes

Shading of Review Determination Column Only=Not subject to review, e.g., header, DMS responsibility
Shading of Columns for Review Determination, Comments and Health Plan's and DMS's Responses and Plan of Action=Not subject to review for the current review year, e.g., standard deemed due to full compliance achieved during prior review.

Grievance System

Final Report 9/5/2014

Suggested Evidence

Documents

Policies/procedures for:

- Grievances including handling of quality-related cases
- Appeals
- State hearings

QI Committee minutes or other documentation demonstrating investigation, evaluation, analysis and follow-up of aggregated grievance and appeal data
Process for quality oversight of grievance processing
Evidence of quality oversight and follow-up for grievance processing

Reports

Quarterly reports of grievances and appeals

File Review

Member and Provider grievance files for a sample of files selected by EQRO
Member and Provider appeal files for a sample of files selected by EQRO
QI Committee minutes or other documentation demonstrating investigation and any action taken for individual grievance and appeal files selected for review by the EQRO

KY EQRO ANNUAL REVIEW
March 2014
Period of Review: January 1, 2013 – December 31, 2013
MCO: Humana CareSource

Final Report 9/5/2014

Health Risk Assessment (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
34.1 Health Risk Assessment			**General Recommendation for Humana CareSource:** Policies, procedures, reports and documents should be consistent with regard to branding/MCO name and specific to Kentucky Medicaid. The full MCO name, Humana CareSource, should be used consistently.	Humana-CareSource is in the process of reviewing policies, procedures, reports, and documents to ensure branding consistency with the "Humana-CareSource" name and logo. Additionally, we are reviewing all policies and procedures to ensure they are Kentucky Medicaid specific.
The Contractor shall have programs and processes in place to address the preventive and chronic healthcare needs of its population. The Contractor shall implement processes to assess, monitor, and evaluate services to all subpopulations, including but not limited to, the on-going special conditions that require a course of treatment or regular care monitoring, Medicaid eligibility category, type of disability or chronic conditions, race, ethnicity, gender and age.		Full	Addressed in P/P W-01, Wellness - Health Screening Assessment Policy and Procedure – KY.	
The Contractor shall conduct initial health screening assessment of new Members who have not been enrolled in the prior twelve (12) month period, for the purpose of assessing the Member's need for any special health care needs within ninety (90) days of Enrollment. Members whose Contractor has a reasonable belief to be pregnant shall be screened within thirty (30) days of Enrollment, and if pregnant, referred for appropriate prenatal care.		Minimal	Per P/P W-01, "the MCO will conduct initial health screening assessments of new members who have not been enrolled in the prior twelve (12) month period for the purpose of assessing the member's need for any special health care needs and within ninety (90) days of enrollment. Members who CareSource has a reasonable belief to be pregnant shall be screened within thirty (30) days of enrollment, and if pregnant, referred for appropriate prenatal care." Per section E.6, the information collected will be used to determine the members' need for care management, disease management,	The contract indicates "The Contractor agrees to make all reasonable efforts to contact new Members in person, by telephone, or by mail to have Members complete the initial health screening questionnaire. Humana – CareSource (HCS) believes that the 2 mailings and publication of the HRA on our web site meets the contract requirement language of reasonable attempts and requests that this standard be moved to full compliance.

Health Risk Assessment (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			behavioral health services and/or other any other health or community services. The New Member Kit, which contains a health risk assessment (HRA), is sent to the new member within a week of identifying the member on the 834 Eligibility File. Within two weeks, additional HRA surveys are sent to members who live in the same household and all members who do not respond to the original attempt. If still not returned, no further outreach until a trigger event occurs. HRA is also available on the MCO's web portal. Humana CareSource tracks date of initial mailing but not subsequent mailings. The HRA outreach process is currently under review. HRA File Review Of the 30 files requested, only 2 had completed HRAs. **Recommendation for Humana CareSource** Humana CareSource should consider using additional methods to encourage completion of the HRA, such as telephone follow-up. Outreach attempts should be documented and tracked.	Although the contract requirement is for reasonable attempt, HCS has explored additional options for improving the rate of HRA completion by members in order to proactively identify members who could benefit from services offered by HCS. HCS has explored several options for improving the rate of HRA completions. These include: • Use of IVR technology to outreach to members to encourage the completion of the HRA is planned for fourth quarter 2014. • During May 2014, two temporary staff were brought on board to make live outbound welcome calls to encourage member completion of an HRA during the call. HCS will evaluate the continuation of live calls based on impact to the HRA completion rate. • Addition of an interactive web based Member Health Assessment 1st Qtr. 2015. Final Review Determination: No change in compliance level. Humana-CareSource was only able to present 2 completed HRAs of 30 requested. This meets the requirement for conducting an initial HRA minimally.

Final Report 9/5/2014

Health Risk Assessment (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
				This finding was reviewed with DMS.
The Contractor agrees to make all reasonable efforts to contact new Members in person, by telephone, or by mail to have Members complete the initial health screening questionnaire.		Minimal	Per P/P W-01, HRAs and a pre-addressed, prepaid return envelope are included in new member kits mailed to all new members at enrollment. Member follow up is done by mail, internet, phone and\or in person. Goal is for HRA completion within 90 days; 30 days for members identified as pregnant. Per the minutes to the Medicaid Compliance and Report/Monitoring & Audit Committee meeting dated 12/17/13, members receive an HRA in the New Member Kit within 1 week of enrollment and 2 follow up letters & HRA form within 2 weeks. High risk members receive a follow up phone call if there is no response within 2 weeks. During the onsite review the process was explained as: A Welcome packet is sent within one week of enrollment. Two weeks later the HRA is sent for all members in the household. If still not returned, no further outreach until a trigger event occurs. The HRA is also available on web portal. Completion of an HRA is promoted in member newsletters. Phone f/u or in person attempts are not currently used. Humana CareSource tracks date of initial mailing but not subsequent mailings.	The contract indicates "The Contractor agrees to make all reasonable efforts to contact new Members in person, by telephone, or by mail to have Members complete the initial health screening questionnaire. Humana – CareSource (HCS) believes that the 2 mailings and publication of the HRA on our web site meets the contract requirement language of reasonable attempts and requests that this standard be moved to full compliance. Although the contract requirement is for reasonable attempt, HCS has explored additional options for improving the rate of HRA completion by members in order to proactively identify members who could benefit from services offered by HCS. HCS has explored several options for improving the rate of HRA completions. These include: • Use of IVR technology to outreach to members to encourage the completion of the HRA is planned for fourth quarter

Health Risk Assessment (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			The MCO reported that the outreach process for conduct of an HRA is currently under review. The MCO is recruiting for a staff person to conduct welcome/outreach calls. In addition, by October 2014, Humana CareSource intends to offer completion of the HRA online to its members. HRA File Review A total of 30 files were requested. Of the 30 files, only 2 enrollees had completed HRAs. For the remaining 28 files: 7 members were mailed a Welcome packet within one week of enrollment; 18 members were mailed a Welcome packet but the mailing date was greater than one week of enrollment /eligibility; two members had a mailing date of UTD and one had a date of NA per documentation provided by the MCO. As noted above, subsequent mailings are not tracked. Quarterly reports indicate the following completion rates: Q1 2013: 305 completed after reasonable effort/12665 new HRAs initiated; 2% Q2 2013: 349/2019; 17% Q3 2013: 368/1445; 25% Q4 2013: 98/1464; 7% **Recommendation for Humana**	2014. • During May 2014, two temporary staff were brought on board to make live outbound welcome calls to encourage member completion of an HRA during the call. HCS will evaluate the continuation of live calls based on impact to the HRA completion rate. • Addition of an interactive web based Member Health Assessment 1st Qtr. 2015. Final Review Determination: No change in compliance level. Only one method of attempted contact was employed – mailing the HRA. Website posting does not meet the requirement for outreach thought it is a good supplemental action. Additionally, the MCO could only provide tracking information/evidence of outreach for one mailed attempt. The outcome of 2 completed HRAs of 30 requested does not provide evidence of all reasonable attempts. This finding was reviewed with DMS.

Final Report 9/5/2014

Health Risk Assessment (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			CareSource Humana CareSource should consider using additional methods to encourage completion of the HRA, such as telephone follow-up. Outreach attempts should be documented and tracked. Humana CareSource should ensure that Welcome packets are mailed within one week of enrollment/eligibility.	
Information to be collected shall include demographic information, current health and behavioral health status to determine the Member's need for care management, disease management, behavioral health services and/ or any other health or community services.		Full	Per P/P W-01, the Humana CareSource Health Assessment questionnaire collects information including demographics, the member's PCP, activity level, tobacco use, alcohol & drug use, nutrition, safety, mood \ mental status, learning style, hearing, vision, preventative screenings, chronic physical & behavioral conditions, access to community services and immunization history. HRA File Review The 2 completed HRAs were compliant.	
The Contractor shall use appropriate healthcare professionals in the assessment process.		Full	Addressed in P/P W-01 section E.6. HRAs are completed by members and returned to the MCO by mail. Nurses screen the completed HRAs to identify members with needs.	
Members shall be offered assistance in arranging an initial visit to their PCP for a baseline medical assessment and other preventative services, including an assessment or screening of the Members potential risk, if any, for specific diseases or conditions.		Full	Per P/P W-01 section E.7, if needed, members will be offered assistance in arranging their initial visit to a PCP for a baseline medical assessment or screening for further risk.	

Final Report 9/5/2014

Health Risk Assessment (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
The Contractor shall submit a quarterly report on the number of new Member assessments; number of assessments completed; number of assessments not completed after reasonable effort; number of refusals.		Full	Per P/P W-01 section E.8, aggregate reporting will be provided quarterly on the number of new member assessments sent, number of new member assessments completed, number not completed and the number of refusals. Humana provided quarterly reports for 2013 - #79 Health Risk Assessment report. Per the Medicaid Compliance and Report/Monitoring & Audit Committee meeting minutes dated 12/17/13, for the month of October 2013, the HRA completion rate was reported at 4%. The completion rate dropped to 2.9% in November. The low completion rate was attributed to "completion rates are reliant on action by the member to return the mailed HRA". The recommendation in the minutes is to "consider new member calls after the member receives their new member kit" in order to produce a substantial increase in the HRA completion rate. The MCO is considering and implementing new processes as described above.	

Final Report 9/5/2014

Health Risk Assessment

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	5	0	2	0
Total Points	15	0	2	0

Overall Compliance Determination:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Range	**3.0**	**2.0 – 2.99**	**1.0 – 1.99**	**0 – 0.99**
Points Average		**2.43**		

As part of the review IPRO assessed the MCO's implementation of any actions proposed by the MCO in response to last year's findings. It should be noted that deficiencies previously identified that continue to be deficient in the current review may adversely affect the scoring of a requirement.

Reviewer Decision:

Full Compliance	MCO has met or exceeded requirements
Substantial Compliance	MCO has met most requirements but may be deficient in a small number of areas
Minimal Compliance	MCO has met some requirements but has significant deficiencies requiring corrective action
Non- Compliance	MCO has not met the requirements
Not Applicable (NA)	Statement does not require a review decision; for reviewer information purposes

Shading of Review Determination Column Only=Not subject to review, e.g., header, DMS responsibility
Shading of Columns for Review Determination, Comments and Health Plan's and DMS's Responses and Plan of Action=Not subject to review for the current review year, e.g., standard deemed due to full compliance achieved during prior review

Health Risk Assessment
Suggested Evidence

Documents

Policies/procedures for:

- Initial health screening assessment (including initial health screening tool)

File Review

File review of a sample of cases selected by the EQRO

Reports

Quarterly reports on the number of new member assessments; number of assessments completed; number of assessments not completed after reasonable effort; number of refusals

Evidence of monitoring of health screening assessment completion rates, and follow-up actions to increase completion rates

KY EQRO ANNUAL REVIEW
March 2014
Period of Review: January 1, 2013 – December 31, 2013
MCO: Humana CareSource

Final Report 9/5/2014

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
27.2 Provider Credentialing and Recredentialing			**General Recommendation for Humana CareSource:** Policies, procedures, reports and documents should be consistent with regard to branding/MCO name and specific to Kentucky Medicaid. The full MCO name, Humana CareSource, should be used consistently.	Humana-CareSource is in the process of reviewing policies, procedures, reports, and documents to ensure branding consistency with the "Humana-CareSource" name and logo. Additionally, we are reviewing all policies and procedures to ensure they are Kentucky Medicaid specific.
In compliance with 907 KAR 1:672 and federal law, the Contractor shall document the procedure, which shall comply with the Department's current policies and procedures, for credentialing and recredentialing of providers with whom it contracts or employs to treat members. This documentation shall include, but not be limited to,		Full	Credentialing Policy 2013 addresses this requirement.	
defining the scope of providers covered,		Full	Credentialing Policy 2013 addresses this requirement.	
the criteria and the primary source verification of information used to meet the criteria,		Full	Credentialing Policy 2013 addresses this requirement. Provider Manual addresses this requirement	
the process used to make decisions and the extent of delegated credentialing and recredentialing arrangements.		Full	Credentialing Policy 2013 addresses this requirement. Provider Manual addresses this requirement Credentialing 2013 Agendas and Minutes are evidence of Delegated Entities reviewed at monthly credentialing meetings.	

Final Report 9/5/2014

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
The contractor shall have a process for receiving input from participating providers regarding credentialing and recredentialling of providers.		Full	Credentialing Policy 2013 addresses this requirement. Provider Manual addresses this requirement	
Those providers accountable to a formal governing body for review of credentials shall include physicians; dentists, advanced registered nurse practitioners, audiologist, CRNA, optometrist, podiatrist, chiropractor, physician assistant, and other licensed or certified practitioners.		Full	Credentialing Policy 2013 addresses this requirement.	
Providers required to be recredentialed by the Contractor per Department policy are physicians, audiologists, certified registered nurse anesthetists, advanced registered nurse practitioners, podiatrists, chiropractors and physician assistants. However, if any of these providers are hospital-based, credentialing will be performed by the Department.		Full	Credentialing Policy 2013 addresses this requirement.	
The contractor shall be responsible for the ongoing review of provider performance and credentialing as specified below:				
A. The contractor shall verify that its enrolled network Providers to whom members may be referred are properly licensed in accordance with all applicable Commonwealth law and regulations, and have in effect such current policies of malpractice insurance as may be required by the Contractor.		Full	Credentialing Policy 2013 addresses this requirement. <u>Credentialing File Review</u> A review of 20 files (10 PCP and 10 Specialist) showed that all contained verification of provider credentials as well as verification of malpractice insurance.	

Final Report 9/5/2014

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
B. The process for verification of Provider credentials and insurance, and any additional facts for further verification and periodic review of Provider performance, shall be embodied in written policies and procedures, approved in writing by the Department.		Full	Credentialing Policy 2013 addresses this requirement.	
C. The Contractor shall maintain a file for each Provider containing a copy of the Provider's current license issued by the Commonwealth and such additional information as may be specified by the Department.		Full	Credentialing Policy 2013 addresses this requirement. Ongoing Monitoring Process Flow indicates the existence of credentialing files. <u>Credentialing File Review</u> During the onsite visit, Humana CareSource provided evidence of maintaining a copy of each Provider's current license.	
D. The process for verification of Provider credentials and insurance shall be in conformance with the Department's policies and procedures. The Contractor shall meet requirements under KRS 295.560 (12) related to credentialing. The Contractor's enrolled providers shall complete a credentialing application in accordance with the Department's policies and procedures.		Full	Humana CareSource provided the State Credentialing Requirements Grid during the onsite visit. <u>Credentialing File Review</u> 20/20 files were compliant.	
The process for verification of Provider credentials and insurance shall include the following:				
A. Written policies and procedures that include the Contractor's initial process for credentialing as well as its re-credentialing process that must occur, at a minimum, every three (3) years;		Full	Credentialing Policy 2013 addresses this requirement.	

Final Report 9/5/2014

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
B. A governing body, or the groups or individuals to whom the governing body has formally delegated the credentialing function;		Full	Credentialing Policy 2013 addresses this requirement. Delegation Oversight Committee Charter & Meeting minutes address this requirement.	
C. A review of the credentialing policies and procedures by the formal body;		Full	The credentialing policies and procedures are reviewed by the Credential Committee monthly and overseen by the Medical Director.	
D. A credentialing committee which makes recommendations regarding credentialing;		Full	Credentialing Policy 2013 addresses this requirement.	
E. Written procedures, if the Contractor delegates the credentialing function, as well as evidence that the effectiveness is monitored;		Full	Credentialing Policy 2013 addresses the written procedures for delegation of the credentialing function. Policy QM-288-01 Provider Quality Review Process addresses this requirement through prospective, concurrent and retrospective reviews. Annual Audit Form CVS Caremark 2013 and Monthly Delegation Reports are evidence of delegated oversight.	
F. Written procedures for the termination or		Full	RR Credentialing and Recredentialing Policy	

Final Report 9/5/2014

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
suspension of Providers; and			2013 briefly addresses denials of credentialing/recredentialing on page 9: "Denials of credentialing and recredentialing should be communicated to the practitioner in writing and should contain the reason for the denial. Administrative denials may be eligible for reconsideration by the Credentials Committee. Practitioners should submit their written request for reconsideration to the medical/dental director within 14 days of receipt of the denial letter. This request should contain a detailed explanation regarding the issues for which the practitioner would like to be reconsidered. Notification of the outcome of this review should be sent in writing to the practitioner. Providers who have been administratively denied after reconsideration are eligible to reapply after two (2) years." Termination and suspension for delegated credentialing is addressed on page 10: "Humana retains the right to approve, suspend and terminate individual practitioner, providers and sites where it has delegated decision making." P/P QM-288-01 Provider Quality Review Process, page 2 under "Purpose and Procedure":"…In the event that Humana	

Final Report 9/5/2014

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			contemplates action that may adversely affect a Provider's status, it is Humana's policy to take action only: (1) in the reasonable belief that the action was in the furtherance of quality health care, (2) after a reasonable effort to obtain the facts of the matter, (3) after adequate notice and hearing procedures are afforded to the Provider involved or after such other procedures as are fair to the Provider under the circumstances (subject to special rules for suspensions described below), and (4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of paragraph (3); On page 5: "Should the Peer Review Committee decide to recommend an action that adversely affects a Provider's status for more than 30 days, it must offer the Provider an opportunity to request a hearing before a separate hearing panel in accordance with the procedures set forth below. The procedures include specific enumerated rights, including the right to notice and assistance of counsel and a reasoned recommendation from the	

Final Report 9/5/2014

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			hearing panel. At the conclusion of the hearing, the hearing panel transmits its written recommendation and reasoning to the Peer Review Committee for its review and recommendation. The Peer Review Committee then submits its recommendation to the CRRC. The written decision, with reasons, of the CRRC is final." The specific procedures are addressed: - On pages 7-8, under "Peer Review Committee Evaluation" - On pages 8-10, under "Interventions" - On pages 11-16, – under "Fair Hearing Plan" - On pages 16-17, under "Immunity and Confidentiality"	
G. Written procedures for, and the implementation of, reporting to the appropriate authorities serious quality deficiencies resulting in suspension or termination of a provider.		Full	Credentialing Policy 2013 addresses this requirement.	
The contractor shall meet requirements under KRS 205.560(12) related to credentialing. Verification of the Providers credentials shall include the following:		Full	The Credentialing Policy 2013 addresses this requirement.	
A. A current valid license or certificate to practice in the Commonwealth of Kentucky.		Minimal	The Credentialing Policy 2013 does not address licensure/certification in the Commonwealth of Kentucky, specifically. The	Revision made to KY Medicaid Credentialing and Recredentialing policy (CR102) to state the following: "When a provider practices in

Final Report 9/5/2014

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			P/P lists requirements for state licensure and verifying state licensure in general. Credentialing File Review 20/20 files were compliant. **Recommendation for Humana CareSource** The Credentialing Policy 2013 should be updated to specifically address the requirement that the practitioner have a current valid license or certificate to practice in the Commonwealth of Kentucky.	the state of Kentucky, Credentialing Operations will verify the provider has a current valid license or certificate to practice in the Commonwealth of Kentucky before making a credentialing or recredentialing decision. Credentialing Operations will verify out of state providers have a current valid license issued by the state in which they practice.
B. A Drug Enforcement Administration (DEA) certificate and number, if applicable;		Full	Credentialing Policy 2013 addresses this requirement. Credentialing File Review 20/20 files were compliant.	
C. Primary source of graduation from medical school and completion of an appropriate residency, or accredited nursing, dental, physician assistant or vision program, as applicable; if provider is not Board Certified.		Full	Credentialing Policy 2013 addresses this requirement. Credentialing File Review 20/20 files were compliant.	
D. Board certification if the practitioner states on the application that the practitioner is board certified in a specialty;		Full	Credentialing Policy 2013 addresses this requirement. Credentialing File Review 20/20 files were compliant.	

Final Report 9/5/2014

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
E. Professional board certification, eligibility for certification, or graduation from a training program to serve children with special health care needs under twenty-one (21) years of age;		Non-Compliance	Not addressed in Credentialing Policy. **Recommendation for Humana CareSource** The Credentialing Policy should be updated to address the requirement of a professional board certification, eligibility for certification, or graduation from a training program to serve children with special health care needs under twenty-one (21) years of age	Humana & CareSource are currently researching this requirement to ensure the best policy and procedure is put into place. Once the research is complete, a P&P will be published.
F. Previous five (5) years work history;		Full	Credentialing Policy 2013 addresses this requirement. Credentialing File Review 20/20 files were compliant.	
G. Professional liability claims history;		Full	Credentialing Policy 2013 addresses this requirement. Credentialing File Review 20/20 files were compliant.	
H. Clinical privileges and performance in good standing at the hospital designated by the Provider as the primary admitting facility, for all providers whose practice requires access to a hospital, as verified through attestation;		Full	Credentialing Policy 2013 addresses this requirement. Credentialing File Review 20/20 files were compliant.	
I. Current, adequate malpractice insurance, as verified through attestation;		Full	Credentialing Policy 2013 addresses this requirement.	

Final Report 9/5/2014

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			Credentialing File Review 20/20 files were compliant.	
J. Documentation of revocation, suspension or probation of a state license or DEA/BNDD number;		Full	Credentialing Policy 2013 addresses this requirement. Credentialing File Review 20/20 files were compliant.	
K. Documentation of curtailment or suspension of medical staff privileges;		Full	Credentialing Policy 2013 addresses this requirement. Credentialing File Review 20/20 files were compliant.	
L. Documentation of sanctions or penalties imposed by Medicare or Medicaid;		Full	Credentialing Policy 2013 addresses this requirement. Credentialing File Review 20/20 files were compliant.	
M. Documentation of censure by the State or County professional association; and		Full	Credentialing Policy 2013 addresses this requirement. Credentialing File Review 20/20 files were compliant.	
N. Most recent information available from the National Practitioner Data Bank.		Full	Credentialing Policy 2013 addresses this requirement. Credentialing File Review 20/20 files were compliant.	

Final Report 9/5/2014

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
The provider shall complete a credentialing application that includes a statement by the applicant regarding:				
A. The ability to perform essential functions of the positions, with or without accommodation;		Full	Credentialing Policy 2013 addresses this requirement. Credentialing File Review 20/20 files were compliant.	
B. Lack of present illegal drug use;		Full	Credentialing Policy 2013 addresses this requirement. Credentialing File Review 20/20 files were compliant.	
C. History of loss of license and felony convictions;		Full	Credentialing Policy 2013 addresses this requirement. Credentialing File Review 20/20 files were compliant.	
D. History of loss or limitation of privileges or disciplinary activity;		Full	Credentialing Policy 2013 addresses this requirement. Credentialing File Review 20/20 files were compliant.	
E. Sanctions, suspensions or terminations imposed by Medicare or Medicaid; and		Full	Credentialing Policy 2013 addresses this requirement. Credentialing File Review 20/20 files were compliant.	

Final Report 9/5/2014

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
F. Applicant attests to correctness and completeness of the application		Full	Credentialing Policy 2013 addresses this requirement. Credentialing File Review 20/20 files were compliant.	
Before a practitioner is credentialed, the Contractor shall verify information from the following organizations and shall include the information in the credentialing files:				
A. National practitioner data bank, if applicable;		Full	Credentialing Policy 2013 addresses this requirement. Credentialing File Review 20/20 files were compliant.	
B. Information about sanctions or limitations on licensure from the appropriate state boards applicable to the practitioner type; and		Full	Credentialing Policy 2013 addresses this requirement. Credentialing File Review 20/20 files were compliant.	
C. Other recognized monitoring organizations appropriate to the practitioner's discipline.		Full	Credentialing Policy 2013 addresses this requirement.	
At the time of credentialing, the Contractor shall perform an initial visit to potential providers, as it deems necessary and/or as required by law.		Full	Credentialing Policy 2013 addresses the requirement of site visits: Practitioner Office Site Quality contained within this credentialing policy states that the QM Department monitors member complaints for all practitioner sites and that site visits are	

Final Report 9/5/2014

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			conducted of offices within 60 days of determining that the complaint threshold has been met. During the onsite, Humana advised, as per NCQA guidelines, an initial visit to potential providers is not required unless issues are identified.	
The Contractor shall document a structured review to evaluate the site against the Contractor's organizational standards and those specified by this contract.		Not Applicable	Not applicable as per Humana. Per DMS, the OIG conducts this structured review.	
The Contractor shall document an evaluation of the medical record documentation and keeping practices at each site for conformity with the Contractors organizational standards and this contract.		Full	Credentialing Policy 2013; Practitioner Office Site Quality states that the site visit form includes an assessment of adequacy of medical record keeping practices. The site visit form for initial credentialing was provided during the onsite visit. Humana CareSource provided the December Site Visit list as evidence of a completed site visit. 2013 MRDR Medical Records Documentation Review Summary was reviewed. The summary is the result of the 2013 annual review of medical records for a sample of physicians providing primary care.	
The Contractor shall have formalized recredentialing procedures. The Contractor shall formally recredential its providers at least every three (3) years. The		Full	Credentialing Policy 2013 addresses this requirement. Recredentialing file review does not apply at this time as operations began in	

Final Report 9/5/2014

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Contractor shall comply with the Department's recredentialing policies and procedures. There shall be evidence that before making a recredentialing decision, the Contractor has verified information about sanctions or limitations on practitioner from:			2013.	
A. A current license to practice;		Full	Credentialing Policy 2013 addresses this requirement.	
B. The status of clinical privileges at the hospital designated by the practitioner as the primary admitting facility;		Full	Credentialing Policy 2013 addresses this requirement.	
C. A valid DEA, if applicable;		Full	Credentialing Policy 2013 addresses this requirement.	
D. Board certification, if the practitioner was due to be recertified or become board certified since last credentialed or recredentialed;		Full	Credentialing Policy 2013 addresses this requirement.	
E. Five (5) year history of professional liability claims that resulted in settlement or judgment paid by or on behalf of the practitioner; and		Substantial	Credentialing Policy 2013 addresses this requirement stated as: "The practitioner has acceptable liability claims history" but does not address five years. During the onsite visit, the MCO advised that liability claims are held for 10 years. **Recommendation for Humana CareSource** Credentialing Policy should be updated to include the timeframe for verification of	Revision made to KY Medicaid Credentialing and Recredentialing policy (CR102) to state the following: "Before making a credentialing or recredentialing decision, Credentialing Operations will verify professional liability claims that resulted in settlement or judgment paid by or on behalf of the practitioner for the previous 5 years are within acceptable standards.

Final Report 9/5/2014

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			professional liability claims.	
F. A current signed attestation statement by the applicant regarding:		Full	Credentialing Policy 2013 addresses this requirement.	
1. The ability to perform the essential functions of the position, with or without accommodation;		Full	Credentialing Policy 2013 addresses this requirement.	
2. The lack of current illegal drug use;		Full	Credentialing Policy 2013 addresses this requirement.	
3. A history of loss, limitation of privileges or any disciplinary action; and		Full	Credentialing Policy 2013 addresses this requirement.	
4. Current malpractice insurance.		Full	Credentialing Policy 2013 addresses this requirement.	
There shall be evidence that before making a recredentialing decision, the Contractor has verified information about sanctions or limitations on practitioner from :		Full	Credentialing Policy 2013 addresses this requirement.	
A. The national practitioner data bank;		Full	Credentialing Policy 2013 addresses this requirement.	
B. Medicare and Medicaid;		Full	Credentialing Policy 2013 addresses this requirement.	
C. State boards of practice, as applicable; and		Full	Credentialing Policy 2013 addresses this	

Final Report 9/5/2014

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			requirement.	
D. Other recognized monitoring organizations appropriate to the practitioner's specialty.		Full	Credentialing Policy 2013 addresses this requirement.	
The Contractor will use the format provided in Appendix H to transmit the listed provider credentialing elements to the Department. A Credentialing Process Coversheet will be generated per provider. The Credentialing Process Coversheet will be submitted electronically to the Department's fiscal agent.		~~Substantial~~ Full	The documents provided do not include evidence of the format used to transmit provider credentialing elements to the Department. Evidence of a Credentialing Process Coversheet and electronic submission to the Department's fiscal agent was not located. Humana CareSource provided evidence of submission of the credentialing file report to the DMS fiscal agent.	Humana disagrees with this determination. This language was in the original Kentucky Medicaid Enrollment (policy CR301) submitted to IPRO for the audit. The policy states "Humana-CareSource will electronically submit completed MAP-811 enrollment forms, supporting documentation, and a Credentialing Process Coversheet to the State for review and determination of enrollment eligibility. <u>Final Review Determination:</u> Full Compliance Humana-CareSource is correct. P/P CR301 Kentucky Medicaid Enrollment was provided during the onsite audit and addresses submission of provider credentialing elements to the Department.
The Contractor shall establish ongoing monitoring of provider sanctions, complaints and quality issues between recredentialing cycles, and take appropriate		Full	Credentialing Policy 2013 addresses this requirement.	

Final Report 9/5/2014

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
action.				
The Contractor shall have written policies and procedures for the initial and on-going assessment of organizational providers with whom it intends to contract or which it is contracted. Providers include, but are not limited to, hospitals, home health agencies, free-standing surgical centers, residential treatment centers and clinics.		Full	Credentialing Policy 2013 addresses this requirement.	
At least every three (3) years, the Contractor shall confirm the provider is in good standing with state and federal regulating bodies, including the Department, and, has been accredited or certified by the appropriate accrediting body and state certification agency or has met standards of participation required by the Contractor.		Full	Credentialing Policy 2013 addresses this requirement.	
The Contractor shall have policies and procedures for altering conditions of the practitioners participation with the Contractor based on issues of quality of care and services.		Full	Policy QM-288-01 Provider Quality Review Process addresses this requirement.	
The Contractor shall have procedures for reporting to the appropriate authorities, including the Department, serious quality deficiencies that could result in a practitioner's suspension or termination.		Full	Per policy QM-288-01 Provider Quality Review Process, action that adversely affects a provider's participation is reported to the National Practitioner Data Bank and appropriate authorities. Ongoing Monitoring Process Flow (Ongoing Monitoring of Medicare/Medicaid/State Sanctions and Medicare Opt-Out Process) also addresses requirement.	

Final Report 9/5/2014

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
If a provider requires review by the Contractor's credentialing Committee, based on the Contractor's quality criteria, the Contractor will notify the Department regarding the facts and outcomes of the review in support of the State Medicaid credentialing process.		Substantial	Not addressed in policy/procedure. CAT II example was submitted as a sample report to DMS of a case where a provider requires review by the Credentialing Committee. **Recommendation for Humana CareSource** Policy QM-288-01 Provider Quality Review Process and/or Credentialing Policy should be revised to address notification to the Department of facts and outcomes by the credentialing committee review based on quality criteria.	Revision made to KY Medicaid Credentialing and Recredentialing policy (CR102) to state the following: "• If a provider requires review by Humana's Credentials Committee due to quality concerns, Credentialing Operations will notify the Kentucky Medicaid Enrollment office. Notification will include a summary of the facts and outcomes of the Committee's review and how the outcome supports the State's Medicaid credentialing process.
The Contractor shall use the provider types summaries listed at: http://chfs.ky.gov/dms/provEnr/Provider+Types.htm		Full	This requirement is addressed in policy CR301 Kentucky Medicaid Enrollment and policy CR102 Kentucky Medicaid Credentialing and Recredentialing.	
28.1 Network Providers to be Enrolled				
The Contractor's Network shall include Providers from throughout the provider community. The Contractor shall comply with the any willing provider statute as described in 907 KAR 1:672 and KRS 304.17A-270. Neither the Contractor nor any of its Subcontractors shall require a Provider to enroll exclusively with its network to provide Covered Services under this Contract as such would violate the requirement of 42 CFR Part 438 to provide Members with continuity of care and choice. The Contractor shall enroll at least one (1) Federally Qualified Health Center (FQHC) into		Full	The Provider Network Adequacy Report addresses this requirement.	

Final Report 9/5/2014

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
its network if there is a FQHC appropriately licensed to provide services in the region or service area and at least one teaching hospital. In addition the Contractor shall enroll the following types of providers who are willing to meet the terms and conditions for participation established by the Contractor: physicians, advanced practice registered nurses, physician assistants, birthing centers, dentists, primary care centers including, home health agencies, rural health clinics, opticians, optometrists, audiologists, hearing aid vendors, pharmacies, durable medical equipment suppliers, podiatrists, renal dialysis clinics, ambulatory surgical centers, family planning providers, emergency medical transportation provider, non-emergency medical transportation providers as specified by the Department, other laboratory and x-ray providers, individuals and clinics providing Early and Periodic Screening, Diagnosis, and Treatment services, chiropractors, community mental health centers, psychiatric residential treatment facilities, hospitals (including acute care, critical access, rehabilitation, and psychiatric hospitals), local health departments, and providers of EPSDT Special Services. The Contractor may also enroll other providers, which meet the credentialing requirements, to the extent necessary to provide covered services to the Members. Enrollment forms shall include those used by the Kentucky Medicaid Program as pertains to the provider type. The Contractor shall use such				

Final Report 9/5/2014

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
enrollment forms as required by the Department. The Department will continue to enroll and certify hospitals, nursing facilities, home health agencies, independent laboratories, preventive health care providers, and hospices. The Medicaid provider file will be available for review by the Contractor so that the Contractor can ascertain the status of a Provider with the Medicaid Program and the provider number assigned by the Kentucky Medicaid Program.				
Providers performing laboratory tests are required to be certified under the CLIA. The Department will continue to update the provider file with CLIA information from the OSCAR file provided by the Centers for Medicare and Medicaid Services for all appropriate providers. This will make laboratory certification information available to the Contractor on the Medicaid provider file.		Full	Provider Manual addresses the requirement of CLIA in the credentialing process.	
The Contractor shall have written policies and procedures regarding the selection and retention of the Contractor's Network. The policies and procedures regarding selection and retention must not discriminate against providers who service high-risk populations or who specialize in conditions that require costly treatment or based upon that Provider's licensure or certification.		Full	Policy 13.01 Credentialing and Recredentialing Policy addresses this requirement.	
If the Contractor declines to include individuals or groups of providers in its network, it shall give affected providers written notice of the reason for its decision.		Full	Policy 13.01 Credentialing and Recredentialing Policy addresses this requirement.	

Final Report 9/5/2014

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
The Contractor must offer participation agreements with currently enrolled Medicaid providers who have received electronic health record incentive funds who are willing to meet the terms and conditions for participation established by the Contractor.		~~Non-Compliance~~ Substantial	The documents provided do not address the requirement to offer participation agreements with currently enrolled Medicaid providers who have received EHR incentives. **Recommendation for Humana CareSource** A policy/procedure addressing enrollment of providers who have received EHR incentive funds should be developed.	Humana-CareSource disagrees with this recommendation. We feel that our P&P Quarterly Non Par Report Review Process is broader than the contract requirement and therefore we are fully compliant. Humana-CareSource reaches out to any provider who is currently enrolled in the KY Medicaid Program for recruitment purposes. However, we are happy to add language that the providers currently enrolled in the KY Medicaid Program and also received electronic health record incentive funds are included in this recruitment initiative. Final Review Determination: Substantial Compliance Humana-CareSource's procedure for outreaching any provider who is enrolled in Kentucky Medicaid for network recruitment does address fulfilling the requirement. However, to be fully compliant with the requirement, the MCO should add the wording regarding "EHR incentive" to its P/P.
28.2 Out-of-Network Providers				
The Department will provide the Contractor with a streamlined enrollment process to assign provider numbers for Out-of-network providers. Only out-of-network hospitals and physicians are allowed to		Substantial	Policy MM-10 Medical Management - Out of Network Referrals and Negotiations addresses this requirement. However, the policy does not address a streamlined	A hard copy of the KY Medicaid Enrollment policy (CR301) was provided to the auditors on site 3/27/14.

Final Report 9/5/2014

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
complete the Registration short form in emergency situations. The Contractor shall, in a format specified by the Department report all out-of-network utilization by Members.			enrollment process to assign provider numbers for out-of-network providers. **Recommendation for Humana CareSource** Policy MM-10 should be updated to include the streamlined enrollment process for out of network providers.	Final Review Determination: No change in compliance level. Humana-CareSource did provide P/P CR301 during the onsite audit, however, language regarding the "streamlined enrollment process" was not found in the document.
28.3 Contractor's Provider Network				
The Contractor may enroll providers in their network who are not participating in the Kentucky Medicaid Program. Providers shall meet the credentialing standards described in Provider Credentialing and Re-Credentialing of this Contract and be eligible to enroll with the Kentucky Medicaid Program. A provider joining the Contractor's Network shall meet the Medicaid provider enrollment requirements set forth in the Kentucky Administrative Regulations and in the Medicaid policy and procedures manual for fee-for-service providers of the appropriate provider type. The Contractor shall provide written notice to Providers not accepted into the network along with the reasons for the non-acceptance. A provider cannot enroll in the Contractor's Network if the provider has active sanctions imposed by Medicare or Medicaid or SCHIP, if required licenses and certifications are not current, if money is owed to the Medicaid Program, or if the Office of the Attorney General has an active fraud investigation involving the Provider or the Provider		Full	Addressed in Credentialing Policy 2013.	

Final Report 9/5/2014

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
otherwise fails to satisfactorily complete the credentialing process. The Contractor shall obtain access to the National Practitioner Database as part of their credentialing process in order to verify the Provider's eligibility for network participation. Federal Financial Participation is not available for amounts expended for providers excluded by Medicare, Medicaid, or SCHIP, except for Emergency Medical Services.				
28.4 Enrolling Current Medicaid Providers				
The Contractor will have access to the Department Medicaid provider file either by direct on-line inquiry access, by electronic file transfer, or by means of an extract provided by the Department. The Medicaid provider master file is to be used by the Contractor to obtain the ten-digit provider number assigned to a medical provider by the Department, the Provider's status with the Medicaid program, CLIA certification, and other information. The Contractor shall use the Medicaid Provider number as the provider identifier when transmitting information or communicating about any provider to the Department or its Fiscal Agent The Contractor shall transmit a file of Provider data specified in this Contract for all credentialed Providers in the Contractor's network on a monthly basis and when any information changes.		Full	During the onsite review, the MCO advised that the State Medicaid provider file is utilized to recruit new providers.	
28.5 Enrolling New Providers and Providers not Participating in Medicaid				

Final Report 9/5/2014

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
A medical provider is not required to participate in the Kentucky Medicaid Program as a condition of participation with the Contractor's Network. If a potential Provider has not had a Medicaid number assigned, the Contractor will obtain all data and forms necessary to enroll within the Contractor's Network, and include the required data in any transmission of the provider file information with the exception of the Medicaid Provider number.		~~Non-Compliance~~ Full	P/P MM-10 Out of Network Referrals and Negotiations and other provided documents do not address enrolling new providers and providers not participating in Medicaid other than fee negotiations for out of network referrals. **Recommendation for Humana CareSource** Humana CareSource should develop a policy to address enrollment of potential providers.	Humana disagrees with this determination. This language was in the original Kentucky Medicaid Enrollment (policy CR301) submitted to IPRO for the audit. The policy states "Humana-CareSource will assist providers who do not have a Kentucky Medicaid provider ID number with the State's enrollment process" and outlines the enrollment process. Final Review Determination: Full Compliance Humana-CareSource is correct. P/P CR301 Kentucky Medicaid Enrollment was provided during the onsite audit and addresses the MCO assisting providers who do not have a Kentucky Medicaid provider ID number with the State's enrollment process.
28.6 Termination of Network Providers or Subcontractors				
Any Provider or Subcontractor who engages in activities that result in suspension, termination, or exclusion from the Medicare or Medicaid program shall be terminated from participation.		Full	KY HUM Medicaid Required Provisions Attachment addresses this requirement.	
The Department shall notify the Contractor of suspension, termination, and exclusion actions taken against Medicaid providers by the Kentucky Medicaid				

Final Report 9/5/2014

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.214)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
program within three business days via e-mail. The Department will notify the Contractor of voluntary terminations within five business days via email.				
The Contractor shall notify the Department of suspension, termination, and exclusion from Contractor's network taken against a Provider within three business days via email. The Contractor shall notify the Department of voluntary terminations within five business days via email. The Contractor will provide all terminations monthly, via the Provider Termination Report as referenced in Appendix K. The Contractor shall terminate the Provider effective the same date as the Medicaid program termination.		Full	This requirement is addressed in policy CR301 Kentucky Medicaid Enrollment and evident in the Ongoing Monitoring Process flow document. In addition, the MCO provided an example of a provider terminated due to malpractice.	

Final Report 9/5/2014

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	73	4	1	1
Total Points	219	8	1	0

Overall Compliance Determination:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Range	**3.0**	**2.0 – 2.99**	**1.0 – 1.99**	**0 – 0.99**
Points Average		**2.89**		

As part of the review IPRO assessed the MCO's implementation of any actions proposed by the MCO in response to last year's findings. It should be noted that deficiencies previously identified that continue to be deficient in the current review may adversely affect the scoring of a requirement.

Reviewer Decision:

Full Compliance	MCO has met or exceeded requirements
Substantial Compliance	MCO has met most requirements but may be deficient in a small number of areas
Minimal Compliance	MCO has met some requirements but has significant deficiencies requiring corrective action
Non- Compliance	MCO has not met the requirements
Not Applicable	Statement does not require a review decision

Shading of Review Determination Column Only=Not subject to review, e.g., header, DMS responsibility
Shading of Columns for Review Determination, Comments and Health Plan's and DMS's Responses and Plan of Action=Not subject to review for the current review year, e.g., standard deemed due to full compliance achieved during prior review

Final Report 9/5/2014

Quality Assessment and Performance Improvement: Structure and Operations – Credentialing
Suggested Evidence

Documents

Policies and Procedures for:

- Enrollment of network providers
- Enrollment of out-of-network providers
- Provider Credentialing and Recredentialing including delegated credentialing
- Monitoring of provider sanctions, complaints and quality issues between recredentialing cycles
- Altering conditions of participation
- Termination/Suspension of providers
- Initial and ongoing assessment of organizational providers

Credentialing Committee description, membership, meeting agendas and minutes

Reports

Reports of oversight of delegated credentialing
Reports to DMS and/or other authorities of serious quality issues that could result in provider suspension or termination
Sample provider file report of provider credentialing for DMS Fiscal Agent
Sample reports to DMS of cases where a provider requires review by the Credentialing Committee

File Review

Sample of Credentialing and Recredentialing files for varied provider types selected by the EQRO

KY EQRO ANNUAL REVIEW
March 2014
Period of Review: January 1, 2013 – December 31, 2013
MCO: Humana CareSource

Final Report 9/5/2014

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
27.3 Primary Care Provider Responsibilities			**General Recommendation for Humana CareSource:** Policies, procedures, reports and documents should be consistent with regard to branding/MCO name and specific to Kentucky Medicaid. The full MCO name, Humana CareSource, should be used consistently.	Humana-CareSource is in the process of reviewing policies, procedures, reports, and documents to ensure branding consistency with the "Humana-CareSource" name and logo. Additionally, we are reviewing all policies and procedures to ensure they are Kentucky Medicaid specific.
A primary care provider (PCP) is a licensed or certified health care practitioner, including a doctor of medicine, doctor of osteopathy, advanced practice registered nurse (including a nurse practitioner, nurse midwife and clinical specialist), physician assistant, or clinic (including a FQHC, primary care center and rural health clinic), that functions within the scope of licensure or certification, has admitting privileges at a hospital or a formal referral agreement with a provider possessing admitting privileges, and agrees to provide twenty-four (24) hours per day, seven (7) days a week primary health care services to individuals. Primary care physician residents may function as PCPs. The PCP shall serve as the member's initial and most important point of contact with the Contractor. This role requires a responsibility to both the Contractor and the Member. Although PCPs are given this responsibility, the Contractors shall retain the ultimate responsibility for monitoring PCP actions to ensure they comply with the Contractor and Department policies.		Full	2013 Provider Manual Kentucky Medicaid addresses this requirement.	
Specialty providers may serve as PCPs under certain circumstances, depending on the Member's needs. The decision to utilize a specialist as the PCP shall be based on agreement among the Member or family, the specialist,		Full	Provider Manual addresses the role of the PCP indicating that a specialist can act as the member's PCP: "for a Member who has a gynecological or obstetrical health care need,	

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
and the Contractor's medical director. The Member has the right to Appeal such a decision in the formal Appeals process.			disability or a chronic illness," (the PCP) "Is a specialist who agrees to provide and arrange for all appropriate primary and preventive care" Provider Manual p. 76 discusses the PCP Referral process and states "in some cases, specialists may provide services or make referrals in the same manner as a PCP." p. 77 Standing Referrals states "The specialist may provide services in the same manner as the PCP for chronic or prolonged care." P/P NO-27 Network Operations – Access and Availability – KY defines the PCP as "for a Member who has a gynecological or obstetrical health care need, disability or chronic illness, is a specialist who agrees to provide and arrange for all appropriate primary and preventive care." P/P SO-19 Service Operations – Member Appeal – Kentucky addresses the member's appeal rights. Provider Manual addresses the member's appeal & grievance process. Addressed in Member Handbook.	
The Contractor shall monitor PCP's actions to ensure he/she complies with the Contractor's and Department's policies including but not limited to the following:				

Final Report 9/5/2014

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
A. Maintaining continuity of the Member's health care;		Full	2013 Provider Manual Kentucky Medicaid addresses this requirement.	
B. Making referrals for specialty care and other Medically Necessary services, both in and out of network, if such services are not available within the Contractor's network;		Full	2013 Provider Manual Kentucky Medicaid addresses this requirement.	
C. Maintaining a current medical record for the Member, including documentation of all PCP and specialty care services;		Full	2013 Provider Manual Kentucky Medicaid addresses this requirement.	
D. Discussing Advance Medical Directives with all Members as appropriate;		Full	2013 Provider Manual Kentucky Medicaid addresses this requirement.	
E. Providing primary and preventative care, recommending or arranging for all necessary preventive health care, including EPSDT for persons under the age of 21 years;		Full	2013 Provider Manual Kentucky Medicaid addresses this requirement.	
F. Documenting all care rendered in a complete and accurate medical record that meets or exceeds the Department's specifications; and		Full	2013 Provider Manual Kentucky Medicaid addresses this requirement.	
G. Arranging and referring members when clinically appropriate, to behavioral health providers		Full	2013 Provider Manual Kentucky Medicaid addresses this requirement.	
Maintaining formalized relationships with other PCPs to refer their Members for after hours care, during certain days, for certain services, or other reasons to extend their practice. The PCP remains solely responsible for the PCP functions (A) through (G) above.		Full	2013 Provider Manual Kentucky Medicaid addresses this requirement.	
The Contractor shall ensure that the following acceptable after-hours phone arrangements are implemented by PCPs in Contractor's Network and that the unacceptable				

Final Report 9/5/2014

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
arrangements are not implemented:				
A. Acceptable				
(1) Office phone is answered after hours by an answering service that can contact the PCP or another designated medical practitioner and the PCP or designee is available to return the call within a maximum of thirty (30) minutes;		Full	P/P QI-05 Member Access to Primary Care Providers After Regular Business Hours addresses this requirement.	
(2) Office phone is answered after hours by a recording directing the Member to call another number to reach the PCP or another medical practitioner whom the Provider has designated to return the call within a maximum of thirty (30) minutes; and		Full	P/P QI-05 Member Access to Primary Care Providers After Regular Business Hours addresses this requirement.	
(3) Office phone is transferred after office hours to another location where someone will answer the phone and be able to contact the PCP or another designated medical practitioner within a maximum of thirty (30) minutes.		Full	P/P QI-05 Member Access to Primary Care Providers After Regular Business Hours addresses this requirement.	
B. Unacceptable				
(1) Office phone is only answered during office hours;		Full	P/P QI-05 Member Access to Primary Care Providers After Regular Business Hours addresses this requirement.	
(2) Office phone is answered after hours by a recording that tells Members to leave a message;		Full	P/P QI-05 Member Access to Primary Care Providers After Regular Business Hours addresses this requirement.	
(3) Office phone is answered after hours by a recording that directs Members to go to the emergency room for any services needed; and		Full	P/P QI-05 Member Access to Primary Care Providers After Regular Business Hours addresses this requirement.	
(4) Returning after-hours calls outside of thirty (30)		Full	P/P QI-05 Member Access to Primary Care	

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
minutes.			Providers After Regular Business Hours addresses this requirement.	
28.7 Provider Program Capacity Demonstration				
The Contractor shall assure that all Covered Services are as accessible to Members (in terms of timeliness, amount, duration, and scope) as the same services as are available to commercial insurance members in the Contractor's Region; and that no incentive is provided, monetary or otherwise, to providers for the withholding from Members of Medically Necessary services.		Full	P/P NO-27 Network Operations-Access and Availability-KY addresses: "member access to services by producing reports illustrating that services, service locations, and service sites are available and accessible in terms of timeliness, amount, duration and personnel sufficient to provide all covered services on an emergency or urgent care basis 24/7. Member Handbook and Provider Manual address requirement. No incentives are provided for withholding medically necessary services is addressed in the Provider Manual.	
The Contractor shall make available and accessible facilities, service locations, and personnel sufficient to provide covered services consistent with the requirements specified in this section.		Full	P/P NO-27 Access and Availability-KY addresses this requirement.	
Emergency medical services shall be made available to Members twenty-four (24) hours a day, seven (7) days a week. Urgent care services by any provider in the Contractor's Program shall be made available within 48 hours of request. The Contractor shall provide the following:		Full	P/P NO-27 Access and Availability-KY addresses this requirement.	
A. Primary Care Provider (PCP) delivery sites that are: no more than thirty (30) miles or thirty (30) minutes from		Full	P/P NO-27 Access and Availability-KY addresses this requirement.	

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Members in urban areas, and for Members in non-urban areas, no more than forty-five (45) minutes or forty-five (45) miles from Member residence; with a member to PCP (FTE) ratio not to exceed 1500:1; and with appointment and waiting times, not to exceed thirty (30) days from date of a Member's request for routine and preventive services and forty-eight (48) hours for Urgent Care.				
B. Specialty care in which referral appointments to specialists shall not exceed thirty (30) days for routine care or forty-eight (48) hours for Urgent Care; except for Behavioral Health Services for which emergency care with crisis stabilization must be provided within twenty-four (24) hours, urgent care which must be provided within forty-eight (48) hours, services may not exceed fourteen (14) days post discharge from an acute Psychiatric Hospital and sixty (60) days for other referrals. Specialists shall be commensurate with the subpopulations designated by the Department, and include sufficient pediatric specialists to meet the needs of Members younger than twenty-one (21) years of age.		Full	Provider Recruitment document and P/P NO-27 Access and Availability-KY address this requirement.	
C. Immediate treatment for Emergency Care at a health facility that is most suitable for the type of injury, illness or condition, regardless of whether the facility is in Contractor's Network.		Full	P/P NO-27 Access and Availability-KY and Covered Services document address this requirement	
D. Hospital care for which transport time shall not exceed thirty (30) minutes, except in non-urban areas where access time may not exceed sixty (60) minutes, with the exception of Behavioral Health Services and physical rehabilitative services where access shall not exceed sixty (60) minutes.		Full	P/P NO-27 Access and Availability-KY addresses this requirement. 12_10_13 Network Adequacy Results report demonstrates compliance with standards.	

Final Report 9/5/2014

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
E. General dental services for which transport time shall not exceed one (1) hour. Any exceptions shall be justified and documented by the Contractor. Appointment and waiting times shall not exceed three (3) weeks for regular appointments and forty eight (48) hours for urgent care.		Full	P/P NO-27 Access and Availability-KY addresses this requirement. 12_10_13 Network Adequacy Results report demonstrates compliance with standards.	
F. General vision, laboratory and radiology services for which transport time shall not exceed one (1) hour. Any exceptions shall be justified and documented by the Contractor. Appointment and waiting times shall not exceed thirty (30) days for regular appointments and forty eight (48) hours for Urgent Care.		Full	P/P NO-27 Access and Availability-KY addresses this requirement. 12_10_13 Network Adequacy Results report demonstrates compliance with standards.	
G. For Pharmacy services, travel time shall not exceed one (1) hour or the delivery site shall not be further than fifty (50) miles from the Member's residence. The Contractor is not required to provide transportation services to Pharmacy services.		Full	P/P NO-27 Access and Availability-KY addresses this requirement. 12_10_13 Network Adequacy Results report demonstrates compliance with standards.	
The Contractor shall attempt to enroll the following Providers in its network as follows:				
A. Teaching hospitals;		Full	During interview, the MCO presented a list of existing providers or attempts to enroll this type of provider.	
B. FQHCs and rural health clinics;		Full	During interview, the MCO presented a list of existing providers or attempts to enroll this type of provider.	
C. The Kentucky Commission for Children with Special Health Care Needs; and		Full	During interview, the MCO presented a list of existing providers or attempts to enroll this type of provider.	
D. Community Mental Health Centers		Full	During interview, the MCO presented a list of existing providers or attempts to enroll this	

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			type of provider.	
If the Contractor is not able to reach agreement on terms and conditions with these specified providers, it shall submit to the Department, for approval, documentation which supports that adequate services and service sites as required in this Contract shall be provided to meet the needs of its Members without contracting with these specified providers.		Full	The MCO provided an email as an example that satisfies this requirement.	
In consideration of the role that Department for Public Health, which contracts with the local health departments play in promoting population health of the provision of safety net services, the Contractor shall offer a participation agreement to public health departments. Such participation agreements shall include the following provisions:				
A. Coverage of the Preventive Health Package pursuant to 907 KAR 1:360.		Full		
B. Provide reimbursement at rates commensurate with those provided under Medicare.		Full		
The Contractor may also include any charitable providers which serve Members in the Contractor Region, provided that such providers meet credentialing standards.		Full	The MCO provided list of charitable providers available to members on their website.	
The Contractor shall demonstrate the extent to which it has included providers who have traditionally provided a significant level of care to Medicaid Members. The Contractor shall have participating providers of sufficient types, numbers, and specialties in the service area to assure quality and access to health care services as required for the Quality Improvement program as		Full	Addressed in P/P NO-27 Network Operations – Access and Availability – KY. Report "12_10_13 Network Adequacy Results.pdf." provides a detailed analysis of provider availability and accessibility by location and provider type.	

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
outlined in Management Information Systems. If the Contractor is unable to contract with these providers, it shall submit to the Department, for approval, documentation which supports that adequate services and service sites as required in the Contract shall be available to meet the needs of its Members.				
28.8 Program Mapping				
The Contractor shall initially submit a series of maps and charts in a format prescribed by the Department that describes the Contractor's Provider Network, as set forth below. The use of computer-generated maps is preferred. Maps shall include geographic detail including highways, major streets and the boundaries of the Contractor's network. In addition to the maps and charts, the Contractor shall provide an analysis of the capacity to serve all categories of Members. The analysis shall address the standards for access to care.		Full	Report "Kentucky Geo Access Report 2013.pdf addresses the requirements. The Provider Manual lists the service area by county that the Plan covers. The Member Handbook details how a Member can locate a provider via the www.caresource.com/ky website or by calling Member Services. Website www.caresource.com/ky provides a link for Members to search for a provider by location or provider type. The website has the capability to display the results in a list format with a detailed map display. P/P NO-27 Network Operations – Access and Availability addresses requirement. Report "12_10_13 Network Adequacy Results.pdf." provides a detailed analysis of availability and accessibility by location and provider type.	

Final Report 9/5/2014

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Maps shall include the location of all categories of Providers or provider sites as follows:				
A. Primary Care Providers (designated by a "P")		Full	Report "Kentucky Geo Access Report 2013.pdf addresses the requirements.	
B. Primary Care Centers, non FQHC and RHC (designated by a "C")		Full	The MCO provided expanded map and/or provider list documents for this type of provider during interview.	
C. Dentists (designated by a "D")		Full	Report Kentucky Geo Access Report 2013.pdf addresses the requirement.	
D. Other Specialty Providers (designated by a "S")		Full	Report Kentucky Geo Access Report 2013.pdf addresses the requirement.	
E. Non-Physician Providers - including nurse practitioners, (designated by a "N") nurse mid-wives (designated by a "M") and physician assistants (designated by a "A")		Full	The MCO provided expanded map and/or provider list documents for this type of provider during interview.	
F. Hospitals (designated by a "H")		Full	Report Kentucky Geo Access Report 2013.pdf addresses the requirement.	
G. After hours Urgent Care Centers (designated by a "U")		Full	The MCO provided expanded map and/or provider list documents for this type of provider during interview.	
H. Local health departments (designated by a "L")		Full	The MCO provided expanded map and/or provider list documents for this type of provider during interview.	
I. Federally Qualified Health Centers/Rural Health Clinics (designated by a "F" or "R" respectively)		Full	The MCO provided expanded map and/or provider list documents for this type of provider during interview.	

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
J. Pharmacies (designated by a "X")		Full	Report Kentucky Geo Access Report 2013.pdf addresses the requirement.	
K. Family Planning Clinics (designated by an "Z")		Full	The MCO provided expanded map and/or provider list documents for this type of provider during interview.	
L. Significant traditional Providers (designated by an "*")		Full	The MCO provided expanded map and/or provider list documents for this type of provider during interview.	
M. Maternity Care Physicians (designated by a "°")		Full	The MCO provided expanded map and/or provider list documents for this type of provider during interview.	
N. Vision Providers (designated by a "V")		Full	Report Kentucky Geo Access Report 2013.pdf addresses the requirement.	
O. Community Mental Health Centers (designated by a "M")		Full	Report Kentucky Geo Access Report 2013.pdf addresses the requirement.	
The Contractor shall update these maps to reflect changes in the Contractor's Network on an annual basis, or upon request by the Department.		Full	Report Kentucky Geo Access Report 2013.pdf addresses the requirements.	
28.9 Expansion and/or Changes in the Network				
If at any time, the Contractor determines that its Contractor Network is not adequate to comply with the access standards specified above, the Contractor shall notify the Department of this situation and submit a corrective action plan to remedy the deficiency. The corrective action plan shall describe the deficiency in detail, including the geographic location and specific regions where the problem exists, and identify specific action steps to be taken by the Contractor and time-		Full	P/P NO-27 Network Operations – Access and Availability – KY addresses this requirement.	

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
frames to correct the deficiency.				
In addition to expanding the service delivery network to remedy access problems, the Contractor shall also make reasonable efforts to recruit additional providers based on Member requests. When Members ask to receive services from a provider not currently enrolled in the network, the Contractor shall contact that provider to determine an interest in enrolling and willingness to meet the Contractor's terms and conditions.		Full	P/P NO-27 Network Operations – Access and Availability – KY addresses this requirement. During interview, plan also stated that it was standard operating procedure to attempt to enroll providers outside of the network when a member requests their services.	
30.1 Medicaid Covered Services				
The Contractor shall provide, or arrange for the provision of, the Covered Services listed in Appendix I to Members in accordance with the Contract standards, and according to the Department's regulations, state plan, policies and procedures applicable to each category of Covered Services. The Contractor shall be required to provide Covered Services to the extent services are covered for Members at the time of Enrollment.		Full	Addressed in P/P SO-22 Service Operations – Statement of Members Rights and Responsibilities and P/P EN-30 Enrollment – New Member Kits and ID Cards. Member Handbook addresses covered services. Document "Kentucky-Covered-Service-Grid.pdf" details covered services offered by the Plan.	
The Contractor shall ensure that the care of new enrollees is not disrupted or interrupted. The Contractor shall ensure continuity of care for new Members receiving health care under fee for service prior to enrollment in the Plan. Appendix I shall serve as a summary of currently Covered Services that the Contractor shall be responsible for providing to Members. However, it is not intended, nor shall it serve as a substitute for the more detailed information relating to Covered Services which is contained in applicable		Full	Addressed in P/P MM-06 Medical Management – Medical Necessity Determination and P/P MM-04 Medical Management – Continuity of Care.	

Final Report 9/5/2014

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
administrative regulations governing Kentucky Medicaid services provision (907 KAR Chapter 1 and 907 KAR 3:005) and individual Medicaid program services manuals incorporated by reference in the administrative regulations.				
After the Execution Date, to the extent a new or expanded Covered Service is added by the Department to Contractor's responsibilities under this Contract, ("New Covered Service") the financial impact of such New Covered Service will be evaluated from an actuarial perspective by the Department, and Capitation Rates to be paid to Contractor hereunder will be adjusted accordingly to 12.2 and 39.16 herein. The determination that a Covered Service is a New Covered Service is at the discretion of the Department. At least ninety (90) days before the effective date of the addition of a New Covered Service, the Department will provide written notice to Contractor of any such New Covered Service and any adjustment to the Capitation Rates herein as a result of such New Covered Service. This notice shall include: (i) an explanation of the New Covered Service; (ii) the amount of any adjustment to Capitation Rates herein as a result of such New Covered Service; and (iii) the methodology for any such adjustment.				
The Contractor may provide, or arrange to provide, services in addition to the services described in Attachment I, provided quality and access are not diminished, the services are Medically Necessary health services and cost-effective. The cost for these additional services shall not be included in the Capitation Rate. The Contractor shall notify and obtain approval from Department for any new services prior to		Full	Addressed in P/P MM-06 Medical Management – Medical Necessity Determination. Humana CareSource also provided document: "Evidence_of_provider_involvement_in_the_review_and_adoption_of_medical_necessity_criteria.pdf". This document is a draft of the Kentucky Clinical Advisory Committee Charter.	

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
implementation. The Contractor shall notify the Department by submitting a proposed plan for additional services and specify the level of services in the proposal.			It states that "The Committee provides a forum for practicing physicians to provide perspective regarding development of clinical policy changes and new program implementation, which helps assure clinical operations remain relevant to practicing clinicians. " The MCO stated during interview that if additional medically necessary services are required, they would create a plan to submit to the Department for review and approval.	
If coverage of any Medicaid service provided by the Contractor requires the completion of a specific form (e.g., hospice, sterilization, hysterectomy, or abortion), the form shall be properly completed according to the appropriate Kentucky Administrative Regulation (KAR). The Contractor shall require its Subcontractor or Provider to retain the form in the event of audit and a copy shall be submitted to the Department upon request.		Full	MCO's website www.caresource.com/providers/kentucky/provider-materials/forms/ addresses the requirement for utilizing the appropriate forms for Provider completion. Provider Manual addresses surgical procedure forms that relate to this requirement and the requirement for retaining copies of a member's medical records.	
The Contractor shall not prohibit or restrict a Provider from advising a beneficiary about his or her health status, medical care, or treatment, regardless of whether benefits for such care are provided under the Contract, if the Provider is acting within the lawful scope of practice.		Full	Addressed in Provider Manual.	
If the Contractor is unable to provide within its network necessary medical services covered under Appendix I, it shall timely and adequately cover these services out of network for the Member for as long as Contractor is unable to provide the services in accordance with 42 CFR		Full	Addressed in Provider Manual.	

Final Report 9/5/2014

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
438.206. The Contractor shall coordinate with out-of-network providers with respect to payment. The Contractor will ensure that cost to the Member is no greater than it would be if the services were provided within the Contractor's Network.				
A Member who has received Prior Authorization from the Contractor for referral to a specialist physician or for inpatient care shall be allowed to choose from among all the available specialists and hospitals within the Contractor's Network, to the extent reasonable and appropriate.		Full	Addressed in Provider Manual and Member Handbook. During the interview, the MCO affirmed that the member has access to all available specialists and hospitals within the Contractor's network.	
32.3 Emergency Care, Urgent Care and Post Stabilization Care				
Emergency Care shall be available to Members 24 hours a day, seven days a week. Urgent Care services shall be made available within 48 hours of request. Post Stabilization Care services are covered and reimbursed in accordance with 42 CFR 422.113(c) and 438.114(c).		Full	Addressed in: Provider Manual, Member Handbook, P/P NO-21 Network Operations – Emergency Services and P/P MM-11 Medical Management – Post Stabilization.	
32.4 Out-of-Network Emergency Care				
The Contractor shall provide, or arrange for the provision of Emergency Care, even though the services may be received outside the Contractor's Network, in accordance with 42 CFR 431.52 and 907 KAR 1:084. These regulations require that the Commonwealth, including Department and its Contractor, cover not only Medically Necessary services due to a medical emergency, but also out-of-state medical services if medical services are needed and the member's health would be endangered if he/she were required to travel to his/her state of		Full	Addressed in Member Handbook and P/P NO-21 Network Operations – Emergency Services.	

Final Report 9/5/2014

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
residence.				
Payment for Emergency Services covered by a non-contracting provider shall not exceed the Medicaid fee-for service rate as required by Section 6085 of the Deficit Reduction Act of 2005.		Full	P/P NO-21 Network Operations – Emergency Services addresses this requirement.	
30.2 Direct Access Services				
The Contractor shall make Covered Services available and accessible to Members as specified in Appendix I. The Contractor shall routinely evaluate Out-of-Network utilization and shall contact high volume providers to determine if they are qualified and interested in enrolling in the Contractor's Network. If so, the Contractor shall enroll the provider as soon as the necessary procedures have been completed. When a Member wishes to receive a direct access service or receives a direct access service from an Out-of-Network Provider, the Contractor shall contact the provider to determine if it is qualified and interested in enrolling in the network. If so, the Contractor shall enroll the provider as soon as the necessary enrollment procedures have been completed.		Full	Addressed in P/P NO-27 Network Operations – Access and Availability – KY.	
The Contractor shall ensure direct access and may not restrict the choice of a qualified provider by a Member for the following services within the Contractor's network:				
A. Primary care vision services, including the fitting of eye-glasses, provided by ophthalmologists, optometrists and opticians;		Full	Addressed in Provider Manual and Member Handbook.	
B. Primary care dental and oral surgery services and evaluations by orthodontists and prosthodontists;		Full	Addressed in Provider Manual and Member Handbook.	

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
C. Voluntary family planning in accordance with federal and state laws and judicial opinion;		Full	Addressed in Member Handbook.	
D. Maternity care for Members under 18 years of age;		Full	Addressed in Member Handbook.	
E. Immunizations to Members under 21 years of age;		Full	Addressed in Provider Manual and Member Handbook.	
F. Sexually transmitted disease screening, evaluation and treatment;		Full	Addressed in Member Handbook.	
G. Tuberculosis screening, evaluation and treatment;		Non-Compliance	Not addressed in the Member Handbook. **Recommendation for Humana CareSource** Direct access for tuberculosis screening, evaluation and treatment should be addressed in the Member Handbook.	We will add to our Member Handbook under Direct Access the following, "Tuberculosis screening, evaluation and treatment." A request to revise the Member Handbook under Direct Access and add "Tuberculosis screening, evaluation and treatment" has been submitted.
H. Testing for Human Immunodeficiency Virus (HIV), HIV-related conditions, and other communicable diseases as defined by 902 KAR 2:020;		Full	Addressed in Member Handbook.	
I. Chiropractic services; and		Full	Addressed in Member Handbook.	
J. Women's health specialists.		Full	Addressed in Member Handbook.	
32.6 Voluntary Family Planning				
The Contractor shall ensure direct access for any Member to a Provider, qualified by experience and training, to provide Family Planning Services, as such services are described in Appendix I to this Contract. The Contractor may not restrict a Member's choice of his or her provider for Family Planning Services. Contractor must assure		Full	Addressed in Provider Manual and Member Handbook.	

Final Report 9/5/2014

Quality Assessment and Performance Improvement: Access (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
access to any qualified provider of Family Planning Services without requiring a referral from the PCP.				
The Contractor shall maintain confidentiality for Family Planning Services in accordance with applicable federal and state laws and judicial opinions for Members under eighteen (18) years of age pursuant to Title X, 42 CFR 59.11, and KRS 214.185. Situations under which confidentiality may not be guaranteed are described in KRS 620.030, KRS 209.010 et. seq., KRS 202A, and KRS 214.185.		Full	Addressed in "RR_2013_Privacy_ENG" which is the Plan's 2013 Ethics & Compliance Training – Privacy. Policy includes link for "HGB Policies and Procedures" which displays a release of information form for Family Planning related information. Member Handbook – Notice of Privacy Practices addresses confidentiality of private health information and the reasons why the law allows and\or requires the plan to share PHI without getting the Member's permission. Also addressed in Provider Manual. The MCO stated during interview they are adding to the 2014 Provider Manual a reminder regarding confidentiality for Family Planning Services in accordance with applicable federal and state laws and judicial opinions for Members under eighteen (18) years of age.	

Quality Assessment and Performance Improvement: Access

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	77	0	0	1
Total Points	231	0	0	0

Overall Compliance Determination:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Range	**3.0**	**2.0 – 2.99**	**1.0 – 1.99**	**0 – 0.99**
Points Average		**2.96**		

As part of the review IPRO assessed the MCO's implementation of any actions proposed by the MCO in response to last year's findings. It should be noted that deficiencies previously identified that continue to be deficient in the current review may adversely affect the scoring of a requirement.

Reviewer Decision:

Full Compliance	MCO has met or exceeded requirements
Substantial Compliance	MCO has met most requirements but may be deficient in a small number of areas
Minimal Compliance	MCO has met some requirements but has significant deficiencies requiring corrective action
Non- Compliance	MCO has not met the requirements
Not Applicable	Statement does not require a review decision

Shading of Review Determination Column Only=Not subject to review, e.g., header, DMS responsibility
Shading of Columns for Review Determination, Comments and Health Plan's and DMS's Responses and Plan of Action=Not subject to review for the current review year, e.g., standard deemed due to full compliance achieved during prior review

Final Report 9/5/2014

Quality Assessment and Performance Improvement: Access
Suggested Evidence

Documents

Policies/procedures for:

- PCP responsibilities
- Provider hours of operation and availability, including after-hours availability
- Provider program capacity requirements
- Access and availability standards
- Emergency care, urgent care and post stabilization care
- Out-of-network emergency care
- Direct access services
- Referral for non-covered services
- Referral and assistance with scheduling for specialty health care services

Process for monitoring of provider compliance with hours of operation and availability, including after-hours availability
Process for monitoring of provider compliance with PCP responsibilities
Sample provider contracts – one per provider type
Provider Manual
Benefit Summary (covered/non-covered services)
Corrective action plan submitted to DMS for inadequate access, if applicable

Final Report 9/5/2014

Reports

Monitoring and follow-up of provider compliance with hours of operation and availability, including after-hours availability
Monitoring of provider compliance with PCP responsibilities
Provider Access and Availability Reports
Provider program capacity/program mapping reports including geo access, in required format for:

- Primary care
- Specialty care
- Emergency care
- Hospital care
- General dental services
- General vision, laboratory and radiology services
- Pharmacy services

Evidence of evaluation, analysis and follow-up related to provider program capacity reports
Reports of Out-of-Network Utilization
Evidence of evaluation, analysis and follow-up related to out-of-network utilization monitoring

KY EQRO ANNUAL REVIEW
March 2014
Period of Review: January 1, 2013 – December 31, 2013
MCO: Humana CareSource

Final Report 9/5/2014

Quality Assessment and Performance Improvement: Access – Utilization Management (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
20.6 Utilization Management			**General Recommendation for Humana CareSource:** Policies, procedures, reports and documents should be consistent with regard to branding/MCO name and specific to Kentucky Medicaid. The full MCO name, Humana CareSource, should be used consistently.	Humana-CareSource is in the process of reviewing policies, procedures, reports, and documents to ensure branding consistency with the "Humana-CareSource" name and logo. Additionally, we are reviewing all policies and procedures to ensure they are Kentucky Medicaid specific.
The Contractor shall have a comprehensive UM program that reviews services for Medical Necessity and that monitors and evaluates on an ongoing basis the appropriateness of care and services.		Full	Addressed in the Humana CareSource Utilization Management (UM) Program Description.	
A written description of the UM program shall outline the program structure and include a clear definition of authority and accountability for all activities between the Contractor and entities to which the Contractor delegates UM activities.		Full	Addressed in the Humana CareSource UM Program Description.	
The description shall include the scope of the program;		Full	Addressed in the Humana CareSource UM Program Description.	
the processes and information sources used to determine service coverage;		Full	Addressed in the Humana CareSource UM Program Description.	
clinical necessity, appropriateness and effectiveness;		Full	Addressed in the Humana CareSource UM Program Description. In addition, the Plan provided Medical Necessity Guidelines for Kentucky 2013 for review.	
policies and procedures to evaluate care coordination, discharge criteria, site of services, levels of care, triage decisions and cultural competence of care delivery;		Full	The Humana CareSource UM Program Description and the 2013 Humana CareSource Kentucky Care Transitions Program address this requirement.	
processes to review, approve, and deny services as needed.		Full	This requirement is addressed in the Humana CareSource Medical Management -Medical	

Final Report 9/5/2014

Quality Assessment and Performance Improvement: Access – Utilization Management (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			Necessity Determination Policy.	
The UM program shall be evaluated annually, including an evaluation of clinical and service outcomes.		Full	This requirement is addressed in the Humana CareSource UM Program Description and evidenced by the 2013 Humana CareSource UM Program Evaluation.	
The UM program evaluation along with any changes to the UM program as a result of the evaluation findings, will be reviewed and approved annually by the Medical Director or the QI Committee.		Full	The Humana CareSource UM Program Description states, "The UM Program is evaluated annually and approved by the Utilization Management Committee." This committee is vice-chaired by a Senior VP Medical Director.	
The Contractor shall adopt national recognized standards and criteria which shall be approved by the Department.		Substantial	The Humana CareSource UM Program Description states that the plan uses nationally recognized standards and criteria; however, document does not address DMS approval. **Recommendation for Humana CareSource** The Program Description should include requirement for Department approval. Humana CareSource should make the DMS approval letter available for the compliance reviewer.	Humana-CareSource agrees with this determination. Humana-CareSource will update the information in the overview section of the UM Program to reflect… "Outcome metrics, policy changes and other program modifications pertaining to Kentucky are reported throughout the year to the Kentucky Humana CareSource Quality Assessment Committee and will be submitted to the Kentucky Department of Medicaid Services for approval." This change will be submitted through the required approval process including the KDMS.
The Contractor shall include appropriate physicians and other providers in Contractor's Network in the review and adoption of Medical Necessity criteria.		Full	This requirement is addressed in the Humana CareSource UM Program Description.	
The Contractor shall have in place mechanisms to check the consistency of application of review		Full	The requirement is addressed in the Medical Management – Quality Monitoring of the	

Quality Assessment and Performance Improvement: Access – Utilization Management (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
criteria.			Utilization Management Activities policy.	
The written clinical criteria and protocols shall provide for mechanisms to obtain all necessary information, including pertinent clinical information, and consultation with the attending physician or other health care provider as appropriate.		Full	The requirement is addressed in the Medical Management – Medical Necessity Determination Policy/Procedure, as well as the Humana CareSource UM Program Description.	
The Medical Director shall supervise the UM program and shall be accessible and available for consultation as needed. Decisions to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, must be made by a physician who has appropriate clinical expertise in treating the Member's condition or disease.		Full	The requirement regarding the Medical Director is addressed in the Humana CareSource UM Program Description. The Medical Management - Medical Necessity Determination Policy states that "all medical necessity determinations that cannot be authorized are reviewed by a Medical Director with a current medical license and preferably who is board certified in his/her specialty. These reviews are usually provided by primary care providers with broad based general medical expertise and clinical experience." <u>UM File Review</u> Of the 10 files reviewed in the sample (5 UM denial files, 5 EPSDT denial files, 10/10 files showed evidence that the reviewer is a health care professional with appropriate clinical expertise.	
The reason for the denial shall be cited.		Full	The requirement is addressed in the Medical Management – Medical Necessity Determination Policy/Procedure. <u>UM File Review</u> 10/10 files showed evidence of the reason for	

Quality Assessment and Performance Improvement: Access – Utilization Management (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			the denial.	
Physician consultants from appropriate medical and surgical specialties shall be accessible and available for consultation as needed.		Full	The requirement is addressed in the Medical Management - Medical Necessity Determination Policy.	
The Medical Necessity review process shall be timely and shall include a provision for expedited reviews in urgent decisions.		Substantial	This requirement is addressed in the Humana CareSource UM Program Description and the Medical Management - Medical Necessity Determination Policy. The MCO submitted the UMC PA data and Report Summary for QAC 7-2013. The MCO demonstrated 100% compliance for meeting timeframes for 4 out of 5 months for non-urgent authorization requests and 5 out of 5 months for urgent authorization requests. UM File Review 9/10 files were processed timely. **Recommendation for Humana CareSource** UM decisions should be completed within the specified timeframes.	Humana-CareSource agrees with this determination. Humana CareSource monitors timeframes for medical necessity reviews as outlined in the UM Program description and Medical Management – Medical Necessity Determination Policy. Should a failure to meet a timeframe occur, a root cause analysis and corrective actions are taken to remediate the issue. Quality auditing is performed as outlined in the Medical Management – Quality Monitoring of the Utilization Management Activities.
A. The Contractor shall submit its request to change any prior authorization requirement to the Department for review.		Substantial	The Humana CareSource UM Program Description states that "Outcome metrics, policy changes and other program modifications pertaining to Kentucky are reported throughout the year to the Kentucky Humana CareSource Quality Assessment Committee". **Recommendation for Humana CareSource**	Humana-CareSource agrees with this determination. Humana-CareSource will update the information in the overview section of the UM Program to reflect… "Outcome metrics, policy changes and other program modifications pertaining to Kentucky are reported throughout the year to the Kentucky Humana CareSource Quality Assessment

Quality Assessment and Performance Improvement: Access – Utilization Management (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			MCO should revise the UM Program Description to include any change to prior authorization requirement must be submitted to DMS for review.	Committee and will be submitted to the Kentucky Department of Medicaid Services for approval." This change will be submitted through the required approval process including the KDMS.
B. For the processing of requests for initial and continuing authorization of services, the Contractor shall require that its subcontractors have in place written policies and procedures and have in effect a mechanism to ensure consistent application of review criteria for authorization decisions.		Full	In the Humana CareSource annual audit tool of the two UM subcontractors (MCNA KY and Beacon KY), it is evident that the plan reviews subcontractor policies and procedures and use of review criteria.	
C. In the event that a Member or Provider requests written confirmation of an approval, the Contractor shall provide written confirmation of its decision within two working days of providing notification of a decision if the decision was not in writing. The written confirmation shall be written in accordance with Member Rights and Responsibilities.		Full	Medical Management - Medical Necessity Determination Policy states that "Members and providers are informed of all prospective approval decisions in writing. Letters are generated at the time of determination and mailed via USPS to the member and provider address provided to the Plan."	
D. The Contractor shall have written policies and procedures that show how the Contractor will monitor to ensure clinical appropriate overall continuity of care.		Full	This requirement is addressed by the Medical Management – Continuity of Care Policy/Procedure.	
E. The Contractor shall have written policies and procedures that explain how prior authorization data will be incorporated into the Contractor's overall Quality Improvement Plan.		Substantial	The Humana CareSource UM Program Description states, "The UM Program is integrated with the following programs, Quality Improvement (QI)…", however, it does not explain, specifically, how prior authorization data will be incorporated into the overall Quality Improvement Plan. "RR CareSource Description Quality Improvement Program" addresses the	Humana-CareSource agrees. Humana-CareSource will update the UM Program to provide a more detailed explanation as to how the UM data is incorporated into the overall QI plan.

Quality Assessment and Performance Improvement: Access – Utilization Management (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			incorporation of prior authorization/utilization data on pages 11-12, under subcommittee descriptions: "Utilization Management Committee - The Utilization Management Committee (UMC) is charged with consideration and approval of decisions related to the Humana CareSource Utilization Management program including administrative and clinical direction, ensuring compliance with Federal, State, and accreditation requirements. The purpose is to ensure Humana CareSource utilization management programs and processes including review and development of clinical criteria used to make utilization review and appeal determinations are developed to promote the quality of care provided to Humana CareSource members consistent with standards of care, and are provided timely and consistently. The committee will measure, monitor and report utilization trends including over and under-utilization." On page 14: "Impact of the pharmaceutical management program including issues related to under- and over-utilization of services" And on page 35: "On an annual basis, Humana CareSource implements quality improvement projects and activities aside from those required by state and federal entities. Projects are chosen based on data analysis both internally and externally to determine what quality improvement activities to focus. Data from the following sources is routinely analyzed and results are used to identify	

Quality Assessment and Performance Improvement: Access – Utilization Management (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			opportunities for improvement: … 4. Utilization/Disease Management **Recommendation for Humana CareSource** Humana CareSource should revise the UM Program Description to specifically describe how prior authorization data is incorporated in the overall Quality Improvement Plan.	
Each subcontract must provide that consistent with 42 CFR Sections 438.6(h) and 422.208, compensation to individuals or entities that conduct UM activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to a Member.		Full	The subcontracts (Beacon Contract and MCNA Contract) contain an agreement between the MCO and the subcontractor that no incentives will be provided for denying medically necessary services to members.	
The program shall identify and describe the mechanisms to detect under-utilization as well as over-utilization of services.		Full	This requirement is addressed in the Humana CareSource UM Program Description.	
The written program description shall address the procedures used to evaluate Medical Necessity, the criteria used, information sources, timeframes and the process used to review and approve the provision of medical services.		Full	This requirement is addressed in the Humana CareSource UM Program Description.	
The Contractor shall evaluate Member satisfaction (using the CAHPS survey) and provider satisfaction with the UM program as part of its satisfaction surveys.		Full	The 2013 Humana CareSource QI Program Evaluation v2 Final demonstrates that the MCO includes UM-related measures in both their member and provider satisfaction surveys. The MCO began enrollment in January 2013, satisfaction surveys had not yet been administered. Both the CAHPS and Provider Satisfaction survey are scheduled for 2014. In	

Quality Assessment and Performance Improvement: Access – Utilization Management (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			addition, the plan provided QI Annual Member Surveys and Special Surveys – KY policy, which noted that CAHPS will be evaluated annually.	
The UM program will be evaluated by DMS on an annual basis.		Full	Humana CareSource UM Program Description states, "The UM Program is evaluated annually and approved by the Utilization Management Committee.	
20.7 Adverse Actions Related to Medical Necessity or Coverage Denials				
The Contractor shall give the Member written notice that meets the language and formatting requirements for Member materials, of any action (not just service authorization actions) within the timeframes for each type of action pursuant to 42 CFR 438.210(c). The notice must explain:		Full	This requirement is addressed in the Medical Management Medical Necessity Determination Policy/Procedure.	
(a) The action the Contractor has taken or intends to take;		Full	This requirement is addressed in the Medical Management – Member-Provider Notification of Initial Determinations Policy/Procedure. <u>UM File Review</u> 10/10 files were compliant.	
(b) The reasons for the action;		Full	This requirement is addressed in the Medical Management – Member-Provider Notification of Initial Determinations Policy/Procedure. <u>UM File Review</u> 10/10 files were compliant.	
(c) The Member's right to appeal;		Full	This requirement is addressed in the Medical Management – Member-Provider Notification of Initial Determinations Policy/Procedure.	

Quality Assessment and Performance Improvement: Access – Utilization Management (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			UM File Review 10/10 files were compliant.	
(d) The Member's right to request a State hearing;		Non-compliance	This requirement is addressed in the Medical Management – Member-Provider Notification of Initial Determinations Policy/Procedure. UM File Review 10/10 files did not show evidence of member's right to a State Fair Hearing included in the notice. Humana advised during the onsite review that the member must exhaust the internal appeal process before requesting a State hearing. Confirmed with DMS that the initial adverse determination notice should inform the member of the right to a State hearing once the MCO appeal process is exhausted. **Recommendation for Humana CareSource** The initial adverse determination notice should include reference to the member's right to a State hearing if the member requests an appeal and the appeal upholds the decision.	Humana-CareSource disagrees with this determination. CareSource understands that a member must exhaust his/her appeal rights before requesting a state fair hearing. Currently, the initial denial letter contains information on filing an appeal, and the appeal upheld letter contains information on filing a state fair hearing. Originally, the letters contained information about both the appeal and the state fair hearing but it caused member confusion so the extraneous information was deleted. We think this is the most accurate and least confusing way to explain to members their rights and asks IPRO and the state to let our letters continue to include only the next step in the appeal process. Final Review Determination: No change in compliance level. It is correct that the member must exhaust the MCO appeal rights before requesting a state hearing. However, it was confirmed with DMS that at at the time of initial denial, the MCOs must disclose the member's right to a SFH after exhausting the appeal rights. This can be communicated in one simple sentence. The entire SFH process need not be described.
(e) Procedures for exercising Member's rights to appeal or file a grievance;		Full	This requirement is addressed in the Medical Management – Member-Provider Notification of Initial Determinations Policy/Procedure.	

Quality Assessment and Performance Improvement: Access – Utilization Management (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			UM File Review 10/10 files were compliant.	
(f) Circumstances under which expedited resolution is available and how to request it; and		Full	This requirement is addressed in the Medical Management – Member-Provider Notification of Initial Determinations Policy/Procedure.	
(g) The Member's rights to have benefits continue pending the resolution of the Appeal, how to request that benefits be continued, and the circumstances under which the Member may be required to pay the costs of these services.		Full	This requirement is addressed in the Medical Management – Member-Provider Notification of Initial Determinations Policy/Procedure. UM File Review 10/10 files were compliant.	
The Contractor must give notice at least: A. Ten (10) days before the date of Action when the Action is a termination, suspension, or reduction of a covered service authorized by the Department, its agent or Contractor, except the period of advanced notice is shortened to 5 days if Member Fraud or Abuse has been determined.		Full	This requirement is addressed in the Medical Management – Medical Necessity Determination Policy/Procedure.	
B. The Contractor must give notice by the date of the Action for the following:				
1. In the death of a Member;		Non-Compliance	The requirement to give notice by the date of the action in the event of the death of a Member was not addressed in the P/P in 2013. However, during the onsite review, the MCO provided a copy of the revised draft Medical Management – Member-Provider Notification of Initial Determinations - Policy MM-15 for review. At the time of the review, the revisions were pending approval. **Recommendation for Humana**	Humana-CareSource agrees with this determination. Medical Management- Member-Provider Notification of Initial Determinations- Policy MM-15 was approved on 04/2014 and include the language for Section B 1

Quality Assessment and Performance Improvement: Access – Utilization Management (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			CareSource The policy revisions should be approved and implemented.	
2. A signed written Member statement requesting service termination or giving information requiring termination or reduction of services (where he understands that this must be the result of supplying that information);		Non-Compliance	The requirement to give notice by the date of the action in the event of a signed written Member statement was not addressed in the policy in 2013. However, during the onsite review, the MCO provided a copy of the revised draft Medical Management – Member-Provider Notification of Initial Determinations - Policy MM-15 for review. At the time of the review, the revisions were pending approval. **Recommendation for Humana CareSource** The policy revisions should be approved and implemented.	Humana-CareSource agrees with this determination. Medical Management- Member-Provider Notification of Initial Determinations- Policy MM-15 was approved on 04/2014 and include the language for Section B 2
3. The Member's admission to an institution where he is ineligible for further services;		Non-Compliance	The requirement to give notice by the date of the action in the event of the Member's admission to an institution where he is ineligible for further services was not addressed in the policy in 2013. However, during the onsite review, the MCO provided a copy of the revised draft Medical Management – Member-Provider Notification of Initial Determinations - Policy MM-15 for review. At the time of the review, the revisions were pending approval. **Recommendation for Humana CareSource** The policy revisions should be approved and implemented.	Humana-CareSource agrees with this determination. Medical Management- Member-Provider Notification of Initial Determinations- Policy MM-15 was approved on 04/2014 and include the language for Section B 3

Quality Assessment and Performance Improvement: Access – Utilization Management (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
4. The Member's address is unknown and mail directed to him has no forwarding address;		Non-Compliance	The requirement to give notice by the date of the action in the event that the Member's address is unknown and mail directed to him has no forwarding address was not addressed in the policy in 2013. However, during the onsite review, the MCO provided a copy of the revised draft Medical Management – Member-Provider Notification of Initial Determinations - Policy MM-15 for review. At the time of the review, the revisions were pending approval. **Recommendation for Humana CareSource** The policy revisions should be approved and implemented.	Humana-CareSource agrees with this determination. Medical Management- Member-Provider Notification of Initial Determinations- Policy MM-15 was approved on 04/2014 and include the language for Section B 4
5. The Member has been accepted for Medicaid services by another local jurisdiction;		Non-Compliance	The requirement to give notice by the date of the action in the event that the Member has been accepted for Medicaid services by another local jurisdiction was not addressed in the policy in 2013. However, during the onsite review, the MCO provided a copy of the revised draft Medical Management – Member-Provider Notification of Initial Determinations - Policy MM-15 for review. At the time of the review, the revisions were pending approval. **Recommendation for Humana CareSource** The policy revisions should be approved and implemented.	Humana-CareSource agrees with this determination. Medical Management- Member-Provider Notification of Initial Determinations- Policy MM-15 was approved on 04/2014 and include the language for Section B 5
6. The Member's physician prescribes the change in the level of medical care;		Non-Compliance	The requirement to give notice by the date of the action in the event that the Member's physician prescribes the change in the level of	Humana-CareSource agrees with this determination.

Quality Assessment and Performance Improvement: Access – Utilization Management (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			medical care was not addressed in the policy in 2013. However, during the onsite review, the MCO provided a copy of the revised draft Medical Management – Member-Provider Notification of Initial Determinations - Policy MM-15 for review. At the time of the review, the revisions were pending approval. **Recommendation for Humana CareSource** The policy revisions should be approved and implemented.	Medical Management- Member-Provider Notification of Initial Determinations- Policy MM-15 was approved on 04/2014 and include the language for Section B 6
7. An adverse determination made with regard to the preadmission screening requirements for nursing facility admissions on or after January 1, 1989;		Non-Compliance	The requirement to give notice by the date of the action in the event of an adverse determination made with regard to the preadmission screening requirements for nursing facility admissions was not addressed in the policy in 2013. However, during the onsite review, the MCO provided a copy of the revised draft Medical Management – Member-Provider Notification of Initial Determinations - Policy MM-15 for review. At the time of the review, the revisions were pending approval. **Recommendation for Humana CareSource** The policy revisions should be approved and implemented.	Humana-CareSource agrees with this determination. Medical Management- Member-Provider Notification of Initial Determinations- Policy MM-15 was approved on 04/2014 and include the language for Section B 7
8. The safety or health of individuals in the facility would be endangered, the Member's health improves sufficiently to allow a more immediate transfer or discharge, an immediate transfer or discharge is required by the member's urgent		Non-Compliance	The requirement to give notice by the date of the action in the event that the safety or health of individuals in the facility…, the Member's health improves sufficiently… an immediate transfer or discharge is required…, or a	Humana-CareSource agrees with this determination. Medical Management- Member-Provider

Quality Assessment and Performance Improvement: Access – Utilization Management (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
medical needs, or a Member has not resided in the nursing facility for thirty (30) days.			Member has not resided in the nursing facility…was not addressed in the policy in 2013. However, during the onsite review, the MCO provided a copy of the revised draft Medical Management – Member-Provider Notification of Initial Determinations - Policy MM-15 for review. At the time of the review, the revisions were pending approval. **Recommendation for Humana CareSource** The policy revisions should be approved and implemented.	Notification of Initial Determinations- Policy MM-15 was approved on 04/2014 and include the language for Section B 8
C. The Contractor must give notice on the date of the Action when the Action is a denial of payment.		Full	The requirement is addressed in the Medical Management-Member Provider Notification of Initial Determinations policy.	
D. The Contractor must give notice as expeditiously as the Member's health condition requires and within State-established timeframes that may not exceed two (2) business days following receipt of the request for service, with a possible extension of up to fourteen (14) additional days, if the Member, or the Provider, requests an extension, or the Contractor justifies a need for additional information and how the extension is in the Member's interest.		Substantial	The Medical Management Medical Necessity Determination Policy addresses the ability of the member or provider to request an extension of up to 14 days. The policy states that non-emergent decisions will be determined within two (2) business days consistent with the State Contract requirement. In regard to non-urgent decisions, there is no mention of the decision being made as expeditiously as the member's health condition requires. During the onsite review, Humana Care Source provided a revised draft version of the Medical Management Medical Necessity Determination	Humana-CareSource agrees with this determination. Medical Management- Medical Necessity Determinations Policy MM-06 was approved on 04/2014 and include the language for Section D

Quality Assessment and Performance Improvement: Access – Utilization Management (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			Policy for review. The revisions are pending approval. Recommendation for Humana CareSource The policy revisions should be approved and implemented.	
If the Contractor extends the timeframe, the Contractor must give the Member written notice of the reason for the decision to extend the timeframe and inform the Member of the right to file a Grievance if he or she disagrees with that decision; and issue and carry out the determination as expeditiously as the Member's health condition requires and no later than the date the extension expires.		Substantial	The Medical Management Medical Necessity Determination Policy states, "Requests for prospective medical or behavioral health reviews may be extended one time for up to 14 calendar days provided that an extension is requested by the member or provider and is necessary because of matters beyond the control of the Plan. Notice is given in writing to the member, prior to the expiration of the initial 14 calendar day period of the circumstances requiring the extension and the date when the decision is expected to be made and of the right to file a grievance if he or she disagrees with the Plan's decision to grant an extension." However, this does not address the plan carrying out the determination as expeditiously as the member's health condition requires. During the onsite review, Humana CareSource provided a revised draft version of the Medical Management Medical Necessity Determination Policy for review. The revisions are pending approval. **Recommendation for Humana CareSource** The policy revisions should be approved and	Humana-CareSource agrees with this determination. Medical Management- Medical Necessity Determinations Policy MM-06 was approved on 04/2014 and include the language for Section D

Quality Assessment and Performance Improvement: Access – Utilization Management (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			implemented.	
E. For cases in which a Provider indicates, or the Contractor determines, that following the standard timeframe could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function, the Contractor must make an expedited authorization decision and provide notice as expeditiously as the Member's health condition requires and no later than two (2) working days after receipt of the request for service.		Substantial	The Medical Management Medical Necessity Determination Policy states, "Kentucky Prospective (Pre-service) Decisions 1. Prospective review of urgent medical or behavioral health care requests in which a Provider indicates or CareSource determines that following the standard timeframe could seriously jeopardize the Member's life or health or ability to attain, maintain or regain maximum function no later than 72 hours (3 calendar days) of receipt of request or as expeditiously as the member's condition warrants." This indicates 3 calendar days, rather than 2 working days after receipt of the request. During the onsite review, Humana CareSource provided a revised draft version of the Medical Management Medical Necessity Determination Policy for review. The policy revisions are pending approval. **<u>Recommendation for Humana CareSource</u>** The policy revisions should be approved and implemented.	Humana-CareSource agrees with this determination. Medical Management- Medical Necessity Determinations Policy MM-06 was approved on 04/2014 and include the language for Section E
F. The Contractor shall give notice on the date that the timeframes expire when service authorization decisions not reached within the timeframes for either standard or expedited service authorizations. An untimely service authorization constitutes a		Substantial	Timeframes for determinations are addressed in the Medical Management Member-Provider Notification of Initial Determinations policy and the Medical Management Medical Necessity Determination Policy. Issuance of notice on the	Humana-CareSource agrees with this determination. Medical Management- Medical Necessity Determinations Policy MM-06 was approved on

Final Report 9/5/2014

Quality Assessment and Performance Improvement: Access – Utilization Management (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.210, 438.404, 422.208, 438.6)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
denial and is thus and adverse action.			date that timeframes expire is not addressed in either policy. During the onsite visit, Humana CareSource presented a revised drafted Medical Management Medical Necessity Determination Policy that includes the following: "Notice will be given on the date that the timeframes expire when service authorization decisions are not reached within the timeframes for either standard or expedited service authorizations. An untimely service authorization constitutes a denial and is thus and adverse action." The policy revisions are pending approval. **Recommendation for Humana CareSource** The policy revisions should be approved and implemented.	04/2014 and include the language for Section F

Quality Assessment and Performance Improvement: Access – Utilization Management

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	32	8	0	9
Total Points	96	16	0	0

Overall Compliance Determination:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Range	**3.0**	**2.0 – 2.99**	**1.0 – 1.99**	**0 – 0.99**
Points Average		**2.29**		

As part of the review IPRO assessed the MCO's implementation of any actions proposed by the MCO in response to last year's findings. It should be noted that deficiencies previously identified that continue to be deficient in the current review may adversely affect the scoring of a requirement.

Reviewer Decision:

Full Compliance	MCO has met or exceeded requirements
Substantial Compliance	MCO has met most requirements but may be deficient in a small number of areas
Minimal Compliance	MCO has met some requirements but has significant deficiencies requiring corrective action
Non- Compliance	MCO has not met the requirements
Not Applicable (NA)	Statement does not require a review decision; for reviewer information purposes

Shading of Review Determination Column Only=Not subject to review, e.g., header, DMS responsibility
Shading of Columns for Review Determination, Comments and Health Plan's and DMS's Responses and Plan of Action=Not subject to review for the current review year, e.g., standard deemed due to full compliance achieved during prior review

Final Report 9/5/2014

Quality Assessment and Performance Improvement: Access – Utilization Management
Suggested Evidence

Documents

Policies/procedures for:

- Utilization management
- Review and adoption of medical necessity criteria
- Monitoring to ensure clinically appropriate overall continuity of care
- Incorporation of prior authorization data into QI plan

UM Program Description
Contracts with any subcontractors delegated for UM
Evidence of provider involvement in the review and adoption of medical necessity criteria
UM Committee description and minutes
Process for detecting under-utilization and over-utilization of services

Reports

UM Program Evaluation
Monitoring of consistent application of review criteria and any follow-up actions
CAHPS Report
Provider Satisfaction Survey Report

File Review

Sample of UM files selected by EQRO

KY EQRO ANNUAL REVIEW
March 2014
Period of Review: January 1, 2013 – December 31, 2013
MCO: Humana CareSource

Final Report 9/5/2014

Program Integrity *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
36. Program Integrity			**General Recommendation for Humana CareSource:** Policies, procedures, reports and documents should be consistent with regard to branding/MCO name and specific to Kentucky Medicaid. The full MCO name, Humana CareSource, should be used consistently.	Humana-CareSource is in the process of reviewing policies, procedures, reports, and documents to ensure branding consistency with the "Humana-CareSource" name and logo. Additionally, we are reviewing all policies and procedures to ensure they are Kentucky Medicaid specific.
The Contractor shall have arrangements and policies and procedures that comply with all state and federal statutes and regulations including 42 CFR 438.608 and Section 6032 of the Federal Deficit Reduction Act of 2005, governing fraud, waste and abuse requirements.				
The Contractor shall develop in accordance with Appendix M, a Program Integrity plan of internal controls and policies and procedures for preventing, identifying and investigating enrollee and provider fraud, waste and abuse. This plan shall include, at a minimum:		Full	Addressed in P/P FW-05 SIU – Fraud, Waste and Abuse. Per P/P FW-05 SIU – Fraud, Waste and Abuse. Section E.2.a: "Special Investigations Unit (SIU) – The CareSource department responsible for member and provider Fraud, Waste and Abuse prevention, coordination, detection, investigation, mitigation and reporting. This *Confidential-Proprietary* department reports up through the Corporate Compliance structure to the Corporate Compliance Officer. This unit establishes controls, evaluates and revises FWA detection procedures to ensure compliance with all Federal and State requirements."	

Final Report 9/5/2014

Program Integrity (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
A. Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable federal and state standards;		Full	P/P FW-05 SIU – Fraud, Waste and Abuse – Section E.2.e addresses the overall goals of the Corporate Compliance Plan. The Corporate Compliance Plan is also addressed on p.9 of the CareSource Corporate Compliance Plan.	
B. The designation of a compliance officer and a compliance committee that are accountable to senior management;		Full	P/P FW-05 SIU – Fraud, Waste and Abuse addresses compliance officer, compliance committee designation and the Investigation Committee. The Corporate Compliance Plan discusses the role of the Corporate Compliance Committee and the specific responsibilities of the Corporate Compliance Officer.	
C. Effective training and education for the compliance officer, the organization's employees, subcontractors, providers and members regarding fraud, waste and abuse;		Full	P/P FW-05 SIU – Fraud, Waste and Abuse addresses training policies & procedures. The Corporate Compliance Plan addresses new employee and annual training covered in the compliance education and training program. The document, 'HCS Mbr and Provider Education Materials', provides members with examples of fraud, consequences of fraud and reporting methods. '2013 Ethics ENG' provides the topics covered in the 2013 Ethics & Training – Fraud, Waste and Abuse program.	

Final Report 9/5/2014

Program Integrity (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			'HCS-MBR and Provider Education Materials' pp. 12-13 provides providers with examples of fraud and reporting methods. The document, "Humana – FWA Training HCP and BP 2013', is a training manual for all Health Care Providers (HCP) and Business Partners (BP) for Fraud, Waste, Abuse (FWA) detection, correction and prevention training.	
D. Effective lines of communication between the compliance officer and the organization's employees;		Full	P/P FW-05 SIU – Fraud, Waste and Abuse addresses fraud reporting mechanisms for providers, delegated entities, vendors, members and employees. Mechanisms include a fraud hotline, compliance & ethics hotline, written report (via mail or website), email and fax. Humana FWA Training HCP and BP 2013 addresses reporting mechanisms. 'Summary CS FWA Detection Activities' states: "lines of communication are widely publicized to members/providers/employees through posters, key-fobs, employee badges, quick reference guides, our internal/external websites, newsletters, the Corporate Compliance Plan, handbooks and manuals. Anyone can report FWA allegations anonymously, if preferred."	
E. Enforcement of standards through disciplinary guidelines;		Full	P/P FW-05 SIU – Fraud, Waste and Abuse addresses the corrective action process. 'CompliancePolicy_2013' addresses disciplinary guidelines and corrective action.	

Final Report 9/5/2014

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			FWA Training HCP and BP 2013 addresses Correction and Disciplinary Action.	
F. Provision for internal monitoring and auditing of the member and provider;		Full	P/P FW-05 SIU – Fraud, Waste and Abuse addresses monitoring & auditing procedures. 'Audit Flow Conducting an Audit' documents flow sheets for the audit process. P/P HUM SIU-KY-025 SUI Audit Plan addresses "guidelines for the scope, conduct and reporting of the performance/operation audit (audits)" 'Compliance Policy 2013' addresses audit policies and procedures. "Detection of Insurance Fraud Waste and Abuse" provides an oversight of the tools and resources used by the SIU for "review of information provided through a variety of sources, including communications from government agencies, industry associations and other private payers. These initiatives also include risk assessment and data analysis to determine which potential fraudulent activities require further investigation." '2013 FWA ENG' provides the topics covered in the 2013 Ethics & Training – Fraud, Waste and Abuse which addresses data analytics, investigative staff and internal\external collaboration activities to detect, correct and prevent fraud, waste and abuse.	

Final Report 9/5/2014

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
G. Provision for prompt response to detected offenses, and for development of corrective action initiatives relating to the Contractor's contract;		Full	P/P FW-05 SIU – Fraud, Waste and Abuse addresses procedures for Investigation. All claims are triaged & prioritized and undergo a preliminary evaluation within 72 hours. Also addressed in P/P FW-06 SIU – Fraud, Waste and Abuse Reporting Policy. 'Humana – FWA Training HCP and BP_2013' addresses discipline and correction.	
H. Provision for internal monitoring and auditing of Contractor and its subcontractors; if issues are found Contractor shall provide corrective action taken to the Department;		Full	P/P FW-05 SIU – Fraud, Waste and Abuse addresses monitoring & auditing procedures. P/P HUM SIU-KY-025 SUI Audit Plan addresses "guidelines for the scope, conduct and reporting of the performance/operation audit (audits)" 'Compliance Policy 2013' addresses audit policies and procedures. 'Audit Flow Conducting an Audit' documents flow sheets for the audit process. P/P FW-05 SIU – Fraud, Waste and Abuse addresses corrective action procedures & policies. 'Humana FWA Training HCP and BP 2013' addresses discipline and correction.	
I. Contractor shall be subject to on-site review; and comply with requests from the department to supply documentation and records;		Full	Addressed in P/P FW-05 SIU – Fraud, Waste and Abuse.	

Final Report 9/5/2014

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
J. Contractor shall create an account receivables process to collect outstanding debt from members or providers; and provide monthly reports of activity and collections to the department;		Full	P/P FW-06 SIU – Fraud, Waste and Abuse Reporting Policy. Section E.2.a Medicaid Program Violation Letters and Collections Report details the Member overpayments and the amount of overpayment collected. Section E.2.f SUR Algorithms Report identifies potential overpayments to Providers and provides details of an identified overpayment amount, revised overpayment amount if adjusted, collected overpayment and the total overpayment amount collected from the Provider.	
K. Contractor shall provide procedures for appeal process;		Full	P/P FW-05 SIU – Fraud, Waste and Abuse addresses the dispute and appeals process.	
L. Contractor shall comply with the expectations of 42 CFR 455.20 by employing a method of verifying with member whether the services billed by provider were received by randomly selecting a minimum sample of 500 claims on a monthly basis;		Full	P/P FW-06 SIU – Fraud, Waste & Abuse Reporting Policy addresses sampling of claims on a monthly basis.	
M. Contractor shall create a process for card sharing cases;		Full	Addressed in the file 'HCS Mbr and Provider Education Materials'. The Member Handbook references ID card sharing as a form of fraud\abuse waste.	
N. Contractor shall run algorithms on Claims data and develop a process and report quarterly to the Department all algorithms run, issues identified, actions taken to address those issues and the overpayments collected;		Full	Addressed in P/P FW-05 SIU – Fraud, Waste and Abuse.	
O. Contractor shall follow cases from the time they are opened until they are closed; and		Full	Addressed in P/Ps FW-05 and FW-06.	

Final Report 9/5/2014

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
P. Contractor shall attend any training given by the Commonwealth/Fiscal Agent or other Contractor's organizations provided reasonable advance notice is given to Contractor of the scheduled training.		Full	P/P FW-05 SIU – Fraud, Waste and Abuse, Section E.8.c: (The MCO) "attends any training as required by state and federal contracts provided reasonable advance notice."	
The plan shall be made available to the Department for review and approval.		Full	P/P FW-05 addresses this requirement.	
10.1 Administration/Staffing				
The Contractor shall provide the following functions that shall be staffed by a sufficient number of qualified persons to adequately provide for the member enrollment and services provided.				
B. A Compliance Director whose responsibilities shall be to ensure financial and programmatic accountability, transparency and integrity. The Compliance Director shall maintain current knowledge of Federal and State legislation, legislative initiatives, and regulations relating to Contractor and oversee the Contractor's compliance with the laws and Contract requirements of the Department. The Compliance Director shall also serve as the primary contact for and facilitate communications between Contractor leadership and the Department relating to Contract compliance issues. The Compliance Director shall also oversee Contractor implementation of and evaluate any actions required to correct a deficiency or address noncompliance with Contract requirements as identified by the Department.		Full	Addressed in P/P FW-05 SIU – Fraud, Waste and Abuse.	
Q, A Program Integrity Coordinator who shall coordinate, manage and oversee the Contractor's		Full	P/P FW-05 SIU – Fraud, Waste and Abuse addresses this requirement.	

Final Report 9/5/2014

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Program Integrity unit to reduce fraud and abuse of Medicaid services.				
37.15 Ownership and Financial Disclosure				
The Contractor agrees to comply with the provisions of 42 CFR 455.104. The Contractor shall provide true and complete disclosures of the following information to Finance, the Department, CMS, and/or their agents or designees, in a form designated by the Department (1) at the time of each annual audit, (2) at the time of each Medicaid survey, (3) prior to entry into a new contract with the Department, (4) upon any change in operations which affects the most recent disclosure report, or (5) within thirty-five (35) days following the date of each written request for such information:		Full	Addressed in P/P FW-05 SIU – Fraud, Waste and Abuse. Annual Disclosure of Ownership dated 7/2/13 addresses ownership disclosure requirements. A total of 5 entities were reviewed and findings are noted below: Humana, Inc. - no officers listed on excluded lists 'CareSource Management Group Co.' – no officers listed on excluded lists Block Vision Inc. – no officers listed on excluded lists Managed Care of North America, Inc – no officers listed on excluded lists Beacon Health Strategies - no officers listed on excluded lists	
A. The name and address of each person with an ownership or control interest in (i) the Contractor or (ii) any Subcontractor or supplier in which the Contractor has a direct or indirect ownership of five percent (5%) or more, specifying the relationship of any listed persons who are related as spouse, parent, child, or sibling;		Full	Addressed in P/P FW-05. Annual Disclosure of Ownership dated 7/2/13. No changes in Ownership indicated. Humana, Inc. is listed as the only entity that owns 5% or more direct or indirect ownership or controlling interest in the Plan.	

Final Report 9/5/2014

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
B. The name of any other entity receiving reimbursement through the Medicare or Medicaid programs in which a person listed in response to subsection (a) has an ownership or control interest;		Full	Annual Disclosure of Ownership dated 7/2/13 – no other entities listed are reimbursed by Medicare and/or Medicaid.	
C. The same information requested in subsections (a) and (b) for any Subcontractors or suppliers with whom the Contractor has had business transactions totaling more than $250,000 during the immediately preceding twelve-month period;		Full	Annual Disclosure of Ownership dated 7/2/13. Section 11 states "HHP hasn't engaged in the provision of Medicaid benefits in KY during the past 5 years, thus no significant business transactions."	
D. A description of any significant business transactions between the Contractor and any wholly-owned supplier, or between the Contractor and any Subcontractor, during the immediately preceding five-year period;		Full	Annual Disclosure of Ownership dated 7/2/13. Section 11 states "HHP hasn't engaged in the provision of Medicaid benefits in KY during the past 5 years, thus no significant business transactions."	
E. The identity of any person who has an ownership or control interest in the Contractor, any Subcontractor or supplier, or is an agent or managing employee of the Contractor, any Subcontractor or supplier, who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the services program under Title XX of the Act, since the inception of those programs;		Full	Addressed in P/P FW-05.	
F. The name of any officer, director, employee or agent of, or any person with an ownership or controlling interest in, the Contractor, any Subcontractor or supplier, who is also employed by the Commonwealth or any of its agencies; and		Full	This requirement was addressed in Annual Disclosure of Ownership dated 7/2/13.	
G. The Contractor shall be required to notify the Department immediately when any change in ownership is anticipated. The Contractor shall		Full	This requirement was addressed in Annual Disclosure of Ownership dated 7/2/13.	

Final Report 9/5/2014

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
submit a detailed work plan to the Department and to the DOI during the transition period no later than the date of the sale that identifies areas of the contract that may be impacted by the change in ownership including management and staff.				
State Contract, Appendix M				
ORGANIZATION: The Contractor's Program Integrity Unit (PIU) shall be organized so that:				
A. Required Fraud, Waste and Abuse activities shall be conducted by staff that shall have sufficient authority to direct PIU activities; and shall include written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable federal and state regulations and standards;		Full	Addressed in P/P FW-05. CS Corporate Compliance Plan addresses this requirement in Section 2.	
B. The unit shall be able to establish, control, evaluate and revise Fraud, Waste and Abuse detection, deterrent and prevention procedures to ensure their compliance with Federal and State requirements;		Full	Addressed in P/P FW-05. '2013FWA ENG' provides the topics covered in the 2013 Ethics & Training – Fraud, Waste and Abuse including data analytics, investigative staff and internal\external collaboration activities to detect, correct and prevent fraud, waste and abuse.	
C. Adequate staff shall be assigned to the PIU to enable them to conduct the functions specified in this Appendix on a continuous and on-going basis; and staffing shall consist of a compliance officer, auditing and clinical staff;		Full	P/P FW-05 SIU – Fraud, Waste and Abuse addresses this requirement.	
D. The unit shall be able to prioritize work coming into the unit to ensure that cases with the greatest		Full	P/P FW-05 SIU – Fraud, Waste and Abuse addresses this requirement.	

Final Report 9/5/2014

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
potential program impact are given the highest priority. Allegations or cases having the greatest program impact include cases involving:			.	
(1) Multi-State fraud or problems of national scope, or Fraud or Abuse crossing service area boundaries;		Full	P/P FW-05 SIU – Fraud, Waste and Abuse addresses this requirement.	
(2) High dollar amount of potential overpayment; or		Full	P/P FW-05 SIU – Fraud, Waste and Abuse addresses this requirement.	
(3) Likelihood for an increase in the amount of Fraud or Abuse or enlargement of a pattern.		Full	P/P FW-05 SIU – Fraud, Waste and Abuse addresses this requirement.	
E. Contractor shall provide ongoing education to Contractor staff on Fraud, Waste and Abuse trends including CMS initiatives;		Full	P/P FW-05 SIU – Fraud, Waste and Abuse addresses this requirement. 'Humana –FWA_Training_HCPandBP_2013' is a training manual for all Health Care Providers and Business Partners for Fraud, Waste, Abuse detection, correction and prevention training.	
F. Contractor shall attend any training given by the Commonwealth/Fiscal Agent or other Contractor's organizations provided reasonable advance notice is given to Contractor of the scheduled training.		Full	Addressed in P/P FW-05 SIU – Fraud, Waste and Abuse.	
FUNCTION: The Contractor shall establish a PIU to identify and refer to the Department any suspected Fraud or Abuse of Members and Providers. The Contractor's PIU shall be responsible for:		Full	Addressed in P/P FW-05 SIU – Fraud, Waste and Abuse.	
A. Preventing Fraud, Waste and Abuse by identifying		Full	Addressed in P/P FW-05 SIU – Fraud, Waste	

Final Report 9/5/2014

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
vulnerabilities in the Contractor's program including identification of member and provider Fraud, Waste and Abuse and taking appropriate action including but not limited to the following: (1) Recoupment of overpayments; (2) Changes to policy; (3) Dispute resolution meetings; and (4) Appeals.			and Abuse.	
B. Proactively detecting incidents of Fraud, Waste and Abuse that exist within the Contractor's program through the use of algorithm, investigations and record reviews;		Full	Detection of Insurance Fraud Waste and Abuse details algorithms, software and tools used by the plan for detecting fraud, waste and abuse. Detection of Insurance Fraud Waste and Abuse provides an oversight of the tools and resources used by the SIU to "review of information provided through a variety of sources, including communications from government agencies, industry associations and other private payers. These initiatives also include risk assessment and data analysis to determine which potential fraudulent activities require further investigation." P/P FW-05 SIU – Fraud, Waste and Abuse addresses this requirement in Section 9. 2013 FWA ENG addresses this requirement.	
C. Determining the factual basis of allegations through investigation concerning fraud or abuse made by Members, Providers and other sources;		Full	P/P FW-05 SIU – Fraud, Waste and Abuse addresses this requirement.	
D. Initiating appropriate administrative actions to collect overpayments, deny or to suspend payments that should not be made;		Full	P/P FW-05 SIU – Fraud, Waste and Abuse addresses this requirement.	

Final Report 9/5/2014

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
E. Referring potential Fraud, Waste and Abuse cases to the OIG (and copying DMS) for preliminary investigation and possible referral for civil and criminal prosecution and administrative sanctions;		Full	P/P FW-05 SIU – Fraud, Waste and Abuse addresses this requirement. P/P FW-06 SIU – Fraud, Waste and Abuse addresses this requirement.	
F. Initiating and maintaining network and outreach activities to ensure effective interaction and exchange of information with all internal components of the Contractor as well as outside groups;		Full	'Detection of Insurance Fraud Waste and Abuse' addresses this requirement.	
G. Making and receiving recommendations to enhance the Contractor's ability to prevent, detect and deter Fraud, Waste or Abuse;		Full	P/P FW-05 SIU – Fraud, Waste and Abuse Section E.16 Identified Weakness / Deficiencies / Noncompliance addresses this requirement.	
H. Providing prompt response to detected offenses and developing corrective action initiatives relating to the Contractor's contract;		Full	Humana –FWA_Training_HCPandBP_2013 addresses this requirement.	
I. Providing for internal monitoring and auditing of Contractor and it subcontractors; and supply the department with quarterly reports on the activity and ad hocs as necessary;		Full	P/P FW-05 and P/P FW-06 SIU address this requirement.	
J. Being subject to on-site review and fully complying with requests from the department to supply documentation and records; and		Full	Addressed in P/P FW-05 SIU – Fraud, Waste and Abuse.	
K. Creating an account receivables process to collect outstanding debt from members or providers and providing monthly reports of activity and collections to the department.		Full	Addressed in P/P FW-05 SIU – Fraud, Waste and Abuse. During the onsite review, the MCO provided report #75 SUR Algorithms – Overpayments.	
The Contractor's PIU shall:				

Final Report 9/5/2014

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
A. Conduct continuous and on-going reviews of all MIS data including Member and Provider Grievances and Appeals for the purpose of identifying potentially fraudulent acts;		Full	Summary-CS FWA Detection Activities addresses MIS methodologies, systems and software utilized to detect fraud, waste and abuse. The On-going Monitoring – Lexis Triage reports address and details the specific monthly and\or quarterly reports that utilize MIS data for fraud detection.	
B. Conduct regularly scheduled post-payment audits of provider billings, investigate payment errors, produce printouts and queries of data and report the results of their work to the Contractor, the Department, and OIG;		Full	The MCO provided a flow chart detailing the Flow for Conducting a General Audit to address this requirement.	
C. Conduct onsite and desk audits of providers and report the results to the Department, including any overpayments identified;		Full	Addressed in P/P FW-05 and P/P FW-06.	
D. Maintain locally cases under investigation for possible Fraud, Waste or Abuse activities and provide these lists and entire case files to the Department and OIG upon demand;		Full	Addressed in P/P FW-05 and P/P FW-06.	
E. Designate a contact person to work with investigators and attorneys from the Department and OIG;		Full	Addressed in P/P FW-05. During the onsite review, the MCO provided a list of the plan specific contact Officers.	
F. Ensure the integrity of PIU referrals to the Department. Referrals if appropriate by the unit shall not be subject to the approval of the Contractor's management or officials;		Full	Addressed in P/P FW-05.	
G. Comply with the expectations of 42 CFR 455.20 by		Full	Addressed in P/P FW-06.	

Final Report 9/5/2014

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
employing a method of verifying with member whether the services billed by provider were received by randomly selecting a minimum sample of 500 claims on a monthly basis;				
H. Run algorithms on claims data and develop a process and report quarterly to the department all algorithms run, issues identified, actions taken to address those issues and the overpayments collected;		Full	Addressed in P/P FW-05 and P/P FW-06.	
I. Have a method for collecting administratively on member overpayments were declined prosecution, known as Medicaid Program Violations (MPV) letters, and recover payments from the member;		Full	Addressed in P/P FW-06.	
J. Comply with the program integrity requirements set forth in 42 CFR 438.608 and provide policies and procedures to the Department for review;		Full	Addressed in P/P FW-05.	
K. Report any provider denied enrollment by Contractor for any reason, including those contained in 42 CFR 455.106, to the Department within 5 days of the enrollment denial;		Full	Addressed in P/P FW-05 and P/P 13.01 Credentialing – Credentialing and Recredentialing Policy.	
L. Have a method for recovering overpayments from providers;		Full	Addressed in the Provider Manual and P/P FW-06. During the onsite review, the MCO provided report #75 SUR Algorithms – Overpayments.	
M. Comply with the program integrity requirements of the Patient Protection and Affordable Care Act as directed by the Department;		Full	This requirement is addressed in the Provider Manual – FWA section.	
N. Correct any weaknesses, deficiencies, or noncompliance items that are identified as a result		Full	Addressed in P/P FW-05.	

Final Report 9/5/2014

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
of a review or audit conducted by DMS, CMS, or by any other State or Federal Agency that has oversight of the Medicaid program. Corrective action shall be completed the earlier of 30 calendar days or the timeframes established by Federal and state laws and regulations; and				
O. Work cooperatively and collaboratively with the Department to enhance the contractors PIU and to address any deficiencies identified.		Full	Addressed in P/P FW-05.	
PATIENT ABUSE: Incidents or allegations concerning physical or mental abuse of Members shall be immediately reported to the Department for Community Based Services in accordance with state law and carbon copy the Department for Medicaid Services and OIG.		Full	Addressed in P/P LG-08 Office of General Counsel - Duty to Report Suspected or Known Child/Adult Abuse or Neglect.	
COMPLAINT SYSTEM: The Contractor's PIU shall operate a process to receive, investigate and track the status of Fraud, Waste and Abuse complaints received from members, providers and all other sources which may be made against the Contractor, providers or members. The process shall contain the following:				
A. Upon receipt of a complaint or other indication of potential fraud or abuse, the Contractor's PIU shall conduct a preliminary inquiry to determine the validity of the complaint;		Full	Addressed in P/P FW-05.	
B. The PIU should review background information and MIS data; however, the preliminary inquiry should not include interviews with the subject concerning the alleged instance of Fraud or Abuse;		Full	Addressed in P/P FW-05. Summary-CS FWA Detection Activities addresses MIS methodologies, systems and software utilized to detect fraud, waste and abuse.	

Final Report 9/5/2014

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			RR 2013FWA ENG provides the topics covered in the 2013 Ethics & Training – Fraud, Waste and Abuse which addresses data analytics, investigative staff and internal\external collaboration activities to detect, correct and prevent fraud, waste and abuse.	
C. Should the preliminary inquiry result in a reasonable belief that the complaint does not constitute Fraud or Abuse, the PIU should not refer the case to OIG; however, the PIU should take whatever actions may be necessary, up to and including, administrative recovery of identified overpayments;		Full	Addressed in P/P FW-05 and Provider Manual.	
D. Should the preliminary inquiry result in a reasonable belief that Fraud or Abuse has occurred, the PIU should refer the case and all supporting documentation to the Department, with a copy to OIG;		Full	Addressed in P/P FW-05 and P/P FW-06.	
E. OIG will review the referral and attached documentation and make a determination as to whether OIG will investigate the case or return it to the PIU for them to conduct a preliminary investigation;		Full	Addressed in P/P FW-06.	
F. OIG will notify the PIU in a timely manner as to whether the OIG will investigate or whether the PIU should conduct a preliminary investigation;				
G. If in the process of conducting a preliminary investigation, the PIU suspects a violation of either criminal Medicaid fraud statutes or the Federal False Claims Act, the PIU shall immediately notify the		Full	Addressed in P/P FW-05 and P/P FW-06.	

Final Report 9/5/2014

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Department with a copy to the OIG of their findings and proceed only in accordance with instructions received from the OIG;				
H. If OIG determines that it will keep a case referred by the PIU, the OIG will conduct an investigation, gather evidence, write a report and forward information to the Department and the PIU for appropriate actions;				
I. If OIG opens an investigation based on a complaint received from a source other than the Contractor, OIG will, upon completion of the investigation, provide a copy of the investigative report to DMS and the PIU for appropriate actions;				
J. If OIG investigation results in a referral to the Attorney General's Medicaid Fraud Control Unit and/or the U.S. Attorney, the OIG will notify DMS and the PIU of the referral. DMS and the PIU should only take actions concerning these cases in coordination with the law enforcement agencies that received the OIG referral;				
K. Upon approval of the Department, Contractor shall suspend provider payments in accordance with Section 6402 (h)(2) of the Affordable Care Act pending investigation of credible allegation of fraud; these efforts shall be coordinated through the Department;		Full	Addressed in P/P FW-05.	
L. Upon completion of the PIU's preliminary investigation, the PIU should provide the Department and OIG a copy of their investigative report, which should contain the following elements:		Full	Addressed in P/P FW-06.	

Final Report 9/5/2014

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
(1) Name and address of subject,		Full	Addressed in P/P FW-06.	
(2) Medicaid identification number,		Full	Addressed in P/P FW-06.	
(3) Source of complaint,		Full	Addressed in P/P FW-06.	
(4) The complaint/allegation,		Full	Addressed in P/P FW-06.	
(5) Date assigned to the investigator,		Full	Addressed in P/P FW-06.	
(6) Name of investigator,		Full	Addressed in P/P FW-06.	
(7) Date of completion,		Full	Addressed in P/P FW-06.	
(8) Methodology used during investigation,		Full	Addressed in P/P FW-06.	
(9) Facts discovered by the investigation as well as the full case report and supporting documentation,		Full	Addressed in P/P FW-06.	
(10) All exhibits or supporting documentation,		Full	Addressed in P/P FW-06.	
(11) Recommendations as considered necessary, for administrative action or policy revision,		Full	Addressed in P/P FW-06.	
(12) Overpayment identified, if any, and recommendation concerning collection.		Full	Addressed in P/P FW-06.	
M. The Contractor's PIU provide OIG and DMS a quarterly member and provider status report of all cases including actions taken to implement recommendations and collection of overpayments;		Full	Addressed in P/P FW-06.	
N. The Contractor's PIU shall maintain access to a follow-up system which can report the status of a particular complaint or grievance process or the status of a specific recoupment; and		Full	Addressed in P/P FW-06. During the onsite, the MCO reviewed the Case Tracking System whereby open activity is documented and tracked through a two level process.	

Final Report 9/5/2014

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
O. The Contractor's PIU shall assure a Grievance and appeal process for Members and Providers in accordance with 907 KAR 1:671 and 907 KAR 1:563.		Full	Addressed in P/P FW-05. P/P SO-20 Service Operations – Member Grievance – Kentucky provides "a grievance system which allows members or their authorized representatives a forum for expressing dissatisfaction with CareSource, our providers, provision of health care services, activities, or behaviors." P/P SO-19 Service Operations – Member Appeal – Kentucky purpose is to "maintain expedited appeal standards in compliance with the rules and regulations set forth by the State of Kentucky, federal agencies, and accreditation bodies to provide members with a process to appeal a health plan action or failure to act in a timely manner."	
REPORTING: The Contractor's PIU shall provide a quarterly in narrative report format all activities and processes for each investigative case (from opening to closure) to the Department within 30 calendar days of investigation closure. If any internal component of the Contractor discovers or is made aware of an incident of possible Member or Provider Fraud, Waste or Abuse, the incident shall be immediately reported to the PIU Coordinator. The Contractor's PIU shall report all cases of suspected Fraud, Waste, Abuse or inappropriate practices by Subcontractors, Members or employees to the Department and OIG.		Full	Addressed in P/P FW-06.	
The Contractor is required to report the following data elements to the Department and the OIG on a		Full	Addressed in P/P FW-06.	

Final Report 9/5/2014

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
quarterly basis, in an excel format:			Program Integrity File Review Three files were reviewed onsite: File 1 – Possible Fraud identified by a Humana CareSource Case Manager regarding a member. File 2 – Eligibility Concern – Not FWA File 3 – Media Concern – Local couple indicted in Medicaid Fraud – not Humana CareSource members.	
(1) PIU Case number;		Full	Addressed in P/P FW-06 and Reports 76 and 77. Program Integrity File Review Of the 3 files reviewed, all 3 contained the PIU Case number.	
(2) OIG Case number;		Not Applicable	Humana CareSource provided as evidence for this requirement the SIU Process Flow chart. The DMS report templates do not include OIG Case number. Program Integrity File Review None of the 3 files warranted an OIG Case number. **Recommendation for DMS** DMS should consider revising the report templates for reports 76 and 77 to include the OIG case number.	
(3) Provider/Member name;		Full	Addressed in P/P FW-06 and Reports 76 and 77.	

Final Report 9/5/2014

Program Integrity *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			Program Integrity File Review Of the 3 files reviewed, all 3 contained the provider/member name.	
(4) Provider/Member number;		Full	Addressed in P/P FW-06 and Reports 76 and 77. Program Integrity File Review Of the 3 files reviewed, 1 file contained member number. The other two files were not applicable.	
(5) Date complaint received by Contractor;		Full	Addressed in P/P FW-06 and Reports 76 and 77. Program Integrity File Review Of the 3 files reviewed, all 3 contained the date complaint received by Contractor.	
(6) Source of complaint, unless the complainant prefers to remain anonymous;		Full	Addressed in P/P FW-06 and Reports 76 and 77. Program Integrity File Review Of the 3 files reviewed, all 3 contained the source of complaint.	
(7) Date opened;		Full	Addressed in P/P FW-06 and Reports 76 and 77. Program Integrity File Review Of the 3 files reviewed, all 3 contained the date opened.	
(8) Summary of complaint;		Full	Addressed in P/P FW-06 and Reports 76 and 77.	

Final Report 9/5/2014

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			Program Integrity File Review Of the 3 files reviewed, all 3 contained the summary of complaint.	
(9) Is complaint substantiated or not substantiated (Y or N answer only under this column);		Not Applicable	Humana CareSource provided as evidence for this requirement the SIU Process Flow chart. The DMS template reports for Reports 76 and 77 do not include this requirement. **Recommendation for DMS** DMS should consider revising the report templates for reports 76 and 77 to include this requirement.	
(10) PIU action taken (only provide the most current update);		Full	Addressed in P/P FW-06 and Reports 76 and 77. Program Integrity File Review None of the 3 files warranted action taken. All 3 files were closed without incident.	
(11) Amount of overpayment (if any);		Full	Addressed in P/P FW-06 and Reports 76 and 77. Program Integrity File Review None of the 3 files were deemed overpayment. All 3 files were closed without incident.	
(12) Administrative actions taken to resolve findings of completed cases including the following information:		Full	Addressed in P/P FW-06 and Reports 76 and 77. Program Integrity File Review: None of the 3 files reviewed warranted action taken. All 3 files were closed without	

Final Report 9/5/2014

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			incident.	
(a)The overpayment required to be repaid and overpayment collected to date;		Full	Addressed in P/P FW-06.	
(b) Describe sanctions/withholds applied to Providers/Members, if any;		Full	Addressed in P/P FW-06.	
(c) Provider/Members appeal regarding overpayment or requested sanctions. If so, list the date an appeal was requested, date the hearing was held, the date of the final decision, and to the extent they have occurred;		Substantial	P/P CL-08 Claims – Provider Appeal: Ohio and Kentucky addresses, in general, the provider's claims appeal process but does not make reference to appeals related to FWA/SIU overpayments. For Members, addressed in P/P FW-05 and P/P SO-19 Service Operations – Member Appeal – Kentucky addresses the appeal process for members. For Providers and members, addressed in P/P FW-05, page 9, item # 11 Correction, which describes provider corrective action, termination and claims dollar recovery and the appeal process related to FWA/SIU, specifically, the SIU Corrective Action Appeals/Dispute Process and SIU Grievance and Appeal Process (KY only). Also addressed in the Provider Manual, section on FWA, under Corrective Actions. **Recommendation for Humana CareSource** In general, the combination of OH and KY requirements in the single P/P (CL-08 and FW-05) is confusing and as noted, sometimes	Humana - Caresource agrees with the recommendation and will establish KY Medicaid specific FWA/SIU policies to ensure all KY requirements are addressed

Final Report 9/5/2014

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			incomplete related to KY requirements. Humana CareSource should establish a KY-specific P/P for this (CL-08 and FW-05) and other MCO procedures and processes.	
(d) Revision of the Contractor's policies to reduce potential risk from similar situations with a description of the policy recommendation, implemented of aforementioned revision and date of implementation; and		Full	Addressed in P/P FW-05.	
(e) Make MIS system edit and audit recommendations as applicable.		Full	Addressed in P/P FW-05.	
AVAILABILITY AND ACCESS TO DATA: The Contractor shall:				
A. Gather, produce, keep and maintain records including, but not limited to, ownership disclosure for all providers and subcontractors, submissions, applications, evaluations, qualifications, member information, enrollment lists, grievances, Encounter data, desk reviews, investigations, investigative supporting documentation, finding letters and subcontracts for a period of 5 years after contract end date;		Full	Addressed in P/P FW-05 and P/P FW-06.	
B. Regularly report enrollment, Provider and Encounter data in a format that is useable by the Department and the OIG;		Full	During the onsite review, Humana CareSource addressed this requirement with a presentation of the reports submitted to DMS and OIG.	
C. Backup, store or be able to recreate reported data upon demand for the Department and the OIG;		Full	Addressed in P/P FW-06. During the onsite review, the MCO presented the Humana CareSource Directed Recovery program which detailed the backup, storage and recreation	

Final Report 9/5/2014

Program Integrity (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			of reported data on demand.	
D. Permit reviews, investigations or audits of all books, records or other data, at the discretion of the Department or OIG, or other authorized federal or state agency; and, shall provide access to Contractor records and other data on the same basis and at least to the same extent that the Department would have access to those same records;		Full	Addressed in P/P FW-05.	
E. Produce records in electronic format for review and manipulation by the Department and the OIG;		Full	Addressed in P/P FW-06. MCO quarterly reports 72, 73, 75, 76 and 77 were provided as evidence.	
F. Allow designated Department staff read access to ALL data in the Contractor's MIS systems; and		Not Applicable	(NOTE: This has been deferred by DMS)	
G. Provide all contracted rates for providers upon request.		Full	Addressed in MCO contract with DMS.	
The Contractor's PIU shall have access to any and all records and other data of the Contractor for purposes of carrying out the functions and responsibilities specified in this Contract.		Full	Addressed in P/P FW-05.	
The Contractor shall cooperate with the OIG, the United States Attorney's Office and other law enforcement agencies in the investigation or fraud or abuse cases.		Full	Addressed in P/P FW-06.	
In the event no action toward collection of overpayments is taken by the Contractor after one hundred and eighty (180) days the Commonwealth may begin collection activity and shall retain any overpayments collected. If the Contractor takes appropriate action to collect overpayments, the		Full	Addressed in P/P FW-05 and P/P FW-06. During the onsite, the MCO provided reports to substantiate this requirement. Report #71 addresses overpayments not taken within 180 days.	

Final Report 9/5/2014

Program Integrity *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations: 438.602, 438.608, 438.610)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Commonwealth will not intervene.				
The Contractor shall provide identity and cover documents and information for law enforcement investigators under cover.		Full	Addressed in P/P FW-05.	

Final Report 9/5/2014

Program Integrity

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	114	1	0	0
Total Points	342	2	0	0

Overall Compliance Determination:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Range	**3.0**	**2.0 – 2.99**	**1.0 – 1.99**	**0 – 0.99**
Points Average		**2.99**		

As part of the review IPRO assessed the MCO's implementation of any actions proposed by the MCO in response to last year's findings. It should be noted that deficiencies previously identified that continue to be deficient in the current review may adversely affect the scoring of a requirement.

Reviewer Decision:

Full Compliance	MCO has met or exceeded requirements
Substantial Compliance	MCO has met most requirements but may be deficient in a small number of areas
Minimal Compliance	MCO has met some requirements but has significant deficiencies requiring corrective action
Non- Compliance	MCO has not met the requirements
Not Applicable (NA)	Statement does not require a review decision; for reviewer information purposes

Shading of Review Determination Column Only=Not subject to review, e.g., header, DMS responsibility
Shading of Columns for Review Determination, Comments and Health Plan's and DMS's Responses and Plan of Action=Not subject to review for the current review year, e.g., standard deemed due to full compliance achieved during prior review

Final Report 9/5/2014

Program Integrity
Suggested Evidence

Documents

Policies/Procedures for:

- post payment audits
- internal monitoring and auditing
- preventive actions
- annual ownership and financial disclosure

Program Integrity Plan including related policies and procedures
Program Integrity training program and evidence of training for Compliance Officer, staff, providers, subcontractors and members
Program Integrity Unit description including Compliance Officer position description
Program Integrity Committee description and minutes
Documentation of annual disclosure of ownership and financial interest including owners/directors, subcontractors and employees
Provider contract provisions for FWA
Vendor contract provisions for FWA

Reports

Evidence of PIU preventive actions and ongoing monitoring of MIS data
Monthly state reporting
Quarterly Program Integrity Reports

File Review

Program Integrity files for a random sample of cases chosen by EQRO
ADO files selected by EQRO

KY EQRO ANNUAL REVIEW
March 2014
Period of Review: January 1, 2013 – December 31, 2013
MCO: Humana CareSource

Final Report 9/5/2014

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
32.1 Early and Periodic Screening, Diagnosis and Treatment (EPSDT)			**General Recommendation for Humana CareSource:** Policies, procedures, reports and documents should be consistent with regard to branding/MCO name and specific to Kentucky Medicaid. The full MCO name, Humana CareSource, should be used consistently.	Humana-CareSource is in the process of reviewing policies, procedures, reports, and documents to ensure branding consistency with the "Humana-CareSource" name and logo. Additionally, we are reviewing all policies and procedures to ensure they are Kentucky Medicaid specific.
The Contractor shall provide all Members under the age of twenty-one (21) years EPSDT services in compliance with the terms of this Contract and policy statements issued during the term of this Contract by the Department or CMS. The Contractor shall file EPSDT reports in the format and within the timeframes required by the terms of this Contract as indicated in Appendix J. The Contractor shall comply with 907 KAR 11:034 that delineates the requirements of all EPSDT providers participating in the Medicaid program.		Substantial	The Member Handbook, the Provider Manual, description of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program on the Humana CareSource website, Provider Orientation within the Provider Portal Training, and the Winter Provider Newsletter all indicate that Humana CareSource members from birth up to 21 years of age are automatically eligible for EPSDT services. The web orientation slides on the Provider Portal state that eligibility begins on the first day of the calendar month. Teens First and Children First Member Brochures also indicate EPSDT services are available from birth up to 21 years of age. The plan is new to the KY Medicaid program in 2013 and will submit its first annual CMS Form 416 on March 15, 2014. Report 24 provides an overview of EPSDT activities from 10/1/13 to 12/31/13, which indicates: outreach was performed to members in need of EPSDT screenings, the start of	Appeal resolution notice will be updated to include the possibility of member liability for the cost of continuing benefits if the fair hearing finds in favor of the plan. HCS has developed a draft EPSDT Program Description as discussed during the annual review audit.

Final Report 9/5/2014

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			Provider Clinical Engagement Initiative, the enhancement of care management coordination services and the kick-off of Babies First Program as an incentive to reach members from birth to 15 months of age. Recommended screenings and components of age appropriate screenings are documented in the Provider Manual. Report 23 indicates that clinical practice guidelines are also posted on Health Care Links page of the Member Portal. These guidelines include the periodicity schedule on American Academy of Pediatrics (AAP) website and the EPSDT overview on the CMS EPSDT website. The Clinical Practice Registry (CPR), described in the Member Identification Tracking Tools document, Preventive Health EPSDT and Individuals with Special Health Care Needs (ISHCN), Well Child screenshot, and Report 24, shows providers actionable preventive health services data by listing claims for PCP visits and preventive health related services. The CPR report is a 16 month go-live deliverable. Also closely related to the CPR is the Member Profile which tracks services delivered to members. In the second operational year for the plan, this report will be enhanced with HEDIS measure-based alerts so providers may identify members' needs. Providers have	

Final Report 9/5/2014

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			access to these reports, which are updated monthly on the Provider Portal. Care management, provider relations, and HEDIS staff use these reports also for provider outreach and education. The CMS-416 Annual EPSDT Participation Reports was provided onsite. This report was recently submitted to DMS and is the first annual report for the MCO. The report shows a total screening rate of 78% and a participant rate of 49%. <u>UM File Review</u> Five UM files related to EPSDT (child members) were reviewed. All files were completed timely and were compliant. <u>Member Appeal File Review</u> Five appeal files related to EPSDT (child members) were reviewed. Files were completed timely but did not address member liability for payment. **<u>Recommendation for Humana CareSource</u>** Appeal resolution notice should include the possibility of member liability for the cost of continuing benefits if the fair hearing finds in favor of the plan. It may be helpful for the plan to develop a separate EPSDT program description that describes the numerous activities and	

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			initiatives involved including, but not limited to, the goals and objectives of the program, the provider responsibilities, member eligibility, the periodicity schedule, Immunization schedule, referral process and coverage of services, care management resources, outreach process, claims/billing, and EPSDT provider tools. This resource document could be used to provide a formal training for care managers, EPSDT Coordinator, and providers. The above recommendation was discussed with the MCO during the onsite review and MCO staff reported that they are already considering developing such a document.	
Health care professionals who meet the standards established in the above-referenced regulation shall provide EPSDT services. Additionally, the Contractor shall:		Full	Preventive Health EPSDT and ISHCN document indicates that all members are assigned a PCP and this is communicated to the member on their ID card. The assigned PCP is chosen using an algorithm based on age, sex, and geography. Members may choose to visit other providers within network and notify the plan of their new PCP. The Provider Manual indicates that PCPs must perform their roles and responsibilities as per 907 KAR 1:320. PCPs are also responsible for serving as an EPSDT source and coordinating care. Targeted education on the EPSDT program	

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			is outlined for providers in the 2013 Provider Manual, the website, provider newsletter, and emails/fax/mailings. Provider representatives provide education on the EPSDT program to providers during onsite visits. The plan also sends monthly reports of members due/overdue for screenings as described above. The Provider Manual and Preventive Health EPSDT and ISHCN document indicates that the plan provides EPSDT forms for providers to document well-child visits and ensure compliance with EPSDT components. Clinician adherence is reviewed as part of the utilization management program according to the Preventive Health EPSDT and ISHCN document. In order to become an EPSDT Provider, MAP-814: EPSDT Special Services Short Form must be submitted according to a summary of the Provider Manual.	
A. Provide, through direct employment with the Contractor or by Subcontract, accessible and fully trained EPSDT Providers who meet the requirements set forth under 907 KAR 1:034*, and who are supported by adequately equipped offices to perform EPSDT services.		Full	The Provider Manual states that routine care must be provided within 30 days of the member's request and suggests that the EPSDT form be used to ensure compliance. Care must be provided in a culturally and linguistically competent manner and members must be treated with respect. PCPs must provide phone coverage afterhours, maintain an up to date medical record, and keep the members contact	

Final Report 9/5/2014

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			information accurate and current. According to the Provider Manual, the plan will conduct an initial educational orientation for all newly contracted providers within thirty (30) days of becoming active. Providers will receive periodic and/or targeted education as needed. Provider site visits confirm office hours, after hours and wheelchair accessibility, use of web-access data, receipt of provider manual, and compliance with the periodicity schedule of EPSDT exams. An office representative must acknowledge these elements were covered during the plan's visit. The Provider Representative must also sign the checklist. The plan provided a sample completed form. The Provider Manual also informs providers that their performance will be monitored and evaluated periodically to measure utilization of preventive health services and HEDIS performance measures. Routine reports are under development. The plan will work with providers to improve their performance and if necessary, develop a corrective action plan. AAP Guidelines and the CDC recommended Immunization Schedule is available on the plan's website, and distributed via the	

Final Report 9/5/2014

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			Provider Manual updates, newsletters, mail/fax/email, and provider representative office visits. In order to become an EPSDT Provider, MAP-814: EPSDT Special Services Short Form must be submitted according to a summary of the Provider Manual.	
B. Effectively communicate information (e.g. written notices, verbal explanations, face to face counseling or home visits when appropriate or necessary) with members and their families who are eligible for EPSDT services [i.e. Medicaid eligible persons who are under the age of twenty-one (21)] regarding the value of preventive health care, benefits provided as part of EPSDT services, how to access these services, and the Member's right to access these services.		Full	The Member Handbook, the Teens First and Children First brochures communicate to members a description of the EPSDT program, ages for well child visits, and what members should expect to receive during these visits. The online member portal has links to clinical guidelines. The job description for the EPSDT Coordinator states this staff member is responsible for telephonic outreach and education of benefits for members. This person also follows up with members regarding future appointments. The Preventive Health EPSDT and ISCHN document shows that other efforts for member outreach and engagement includes child health events that promote preventive screenings for ages 3-6 years and adolescents. Members who attend receive back packs and school supplies. The plan assists providers with appointment	

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			scheduling during these events. EPSDT services are also promoted through school based clinics. The document 'RR CM Policy and Procedure' details the role of the Care Manager as an additional level of support and monitoring for members needing EPSDT/preventive services. This is especially true for members with special health care needs. These managers also outreach to new members to conduct health screening assessments via phone, mailings, or in person visits within 90 days of enrollment.	
Members and their families shall be informed about EPSDT and the right to Appeal any decision relating to Medicaid services, including EPSDT services, upon initial enrollment and annually thereafter where Members have not accessed services during the year.		Full	The Member Handbook provides information on the EPSDT services and eligibility. EPSDT Care Management is available to all eligible members. The first EPSDT exam should fall within 90 days of enrollment. Details on the appeals process and submission of grievances are described in the Member Handbook.	
C. Provide EPSDT services to all eligible Members in accordance with EPSDT guidelines issued by the Commonwealth and federal government and in conformance with the Department's approved periodicity schedule, a sample of which is included in Appendix J.		Full	The EPSDT Clinical Guidelines section of the plan's website links to CHIP EPSDT Guidelines, AAP Bright Futures, and the Centers for Disease Control (CDC) Immunization Schedule. The Winter Provider Newsletter directs providers to guidelines posted on the website as well as an online checklist to use to ensure documentation of exam components. The EPSDT Program section of the website lists	

Final Report 9/5/2014

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			exam components and frequencies, information about the Vaccine for Children Program, and the Blood Lead Screening Program. This webpage also indicates providers will receive monthly reports of members that are due for EPSDT services. This report is also accessible on the Provider Portal. The sample Provider Site Visit Form indicates the provider receives education on the EPSDT periodicity schedule from the Provider Representative during on site visits. The Preventive Health EPSDT and ISHCN document states that guidelines are promoted to providers through newsletters, website, mailings, and focused meetings with Provider Representatives. The guidelines are reviewed every 2 years by the Quality Enterprise Committee and Clinical Advisory Committee. EPSDT is a topic identified for review.	
D. Provide all needed initial, periodic and inter-periodic health assessments in accordance with 907 KAR 1:034*. The Primary Care Provider assigned to each eligible member shall be responsible for providing or arranging for complete assessments at the intervals specified by the Department's approved periodicity schedule and at other times when Medically Necessary.		Substantial	The Provider Manual states that routine care must be provided within 30 days of the members request and suggests that the EPSDT form be used to ensure compliance. Care must be provided in a culturally and linguistically competent manner and members must be treated with respect. PCPs must provide phone coverage afterhours; maintain an up to date medical	Humana CareSource disagrees with this determination. Humana CareSource is conducting this review during 2014. This compliance with clinical practice guidelines record review will measure adolescent prevention CPG (EPSDT visit requirements) ages 13 up to

Final Report 9/5/2014

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			record; and keep the members contact information accurate and current. Provider Site visits confirm office hours, after hours and wheelchair accessibility, use of web-access data, receipt of provider manual, and compliance with the periodicity schedule of EPSDT exams. Education on the periodicity schedule is provided. An office representative must acknowledge these elements were covered during the plan's visit. The Provider Representative must also sign the checklist. The plan provided a sample completed form (Provider Site Visit Form). The site visit is practice-specific and does not include review of member-specific medical records for EPSDT services. Per Humana CareSource, every 3 years the MCO will monitor compliance with clinical practice guidelines. In 2014, Humana CareSource will begin measuring compliance with primary care clinical practice guidelines including preventive guidelines for EPSDT. This process will begin after completion of HEDIS data collection (Spring 2014). **Recommendation for Humana CareSource** Humana CareSource should proceed with monitoring primary care records to assess	21st birthday and is in compliance with the contract requirement. Final Review Determination: No change in compliance level. The review for Provider Compliance with EPSDT guidelines is planned for 2014. The period of review is CY 2013. Although Humana-CareSource's stated procedure for Provider Site visits includes confirming compliance with the periodicity schedule of EPSDT exams and education on the periodicity schedule. The Provider Visit Form/checklist did not include evidence of a review of records to confirm provision of EPSDT services.

Final Report 9/5/2014

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			compliance with the Department's periodicity schedule and EPSDT requirements.	
E. Provide all needed diagnosis and treatment for eligible Members in accordance with 907 KAR 1:034*. The Primary Care Provider and other Providers in the Contractor's Network shall provide diagnosis and treatment, and/or Out-of-Network Providers may provide treatment if the service is not available with the Contractor's Network.		Full	The Clinical Practice Registry (CPR), described in the Member Identification Tracking Tools document, Preventive Health EPSDT and ISHCN, Well Child screenshot, and Report 24, shows providers actionable preventive health services data by listing claims for PCP visits and preventive health related services. The CPR report is a 16 month Go Live deliverable. Also closely related to the CPR is the Member Profile which tracks services delivered to members. In the second operational year for the plan, this report will be enhanced with HEDIS measure-based alerts so providers may identify members' needs. Providers have access to these reports, which are updated monthly on the Provider Portal. Care management, provider relations, and HEDIS staff use these reports also for provider outreach and education. The Provider Manual instructs PCPs to make referrals by documenting diagnosis and need for specialty care in the member's medical record. There is no form for submission; however, the PCP is required to contact the referral specialist on the member's behalf and follow-up care. The plan considers referrals for care of chronic conditions and children with special health	

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			care needs to be standing referrals lasting for one or more years. Prior authorizations are required for referrals to out of network specialists. These authorization requests can be submitted online at the Provider Portal or by email/fax/mail/phone. The Member Handbook indicates that special services are covered by the plan if deemed medically necessary. More information on this process s available by calling Member Services. As per the Provider Manual, EPSDT certified dental providers can submit claims for EPSDT dental procedures. Special services require preauthorization by Managed Care North America Dental (MCNA Dental), the plan's dental subcontractor. The preauthorization form should be submitted electronically on MCNA Dental portal with supporting documentation. A separate American Dental Association (ADA) form can be submitted indicating need for EPSDT services.	
F. Provide EPSDT Special Services for eligible members, including identifying providers who can deliver the Medically Necessary services described in federal Medicaid law and developing procedures for authorization and payment for these services. Current requirements for EPSDT Special Services are included in Appendix J.		Full	The Member Handbook indicates that special services are covered by the plan if deemed medically necessary. More information on this process is available by calling Member Services. According to the Provider Manual, the plan considers referrals for care of chronic	

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			conditions and children with special health care needs to be standing referrals lasting for one or more years. Prior authorizations are required for referrals to out of network specialists. These authorization requests can be submitted online at the Provider Portal or by email/fax/mail/phone. The document 'RR CM Policy and Procedure' reveals the plan uses a trigger list of conditions to identify members for care management. The care manager becomes the point of contact to coordinate care between PCPs and specialists. Individuals with special health care needs are eligible for high risk care management programs. The stratification of enrollment in care management is based on predictive risk scoring. The plan identifies members with special health care needs using the Johns Hopkins Adjusted Clinical Groups for predictive modeling as described in the Preventive Health EPSDT and ISHCN document. This model is documented in the Member Profile.	
G. Establish and maintain a tracking system to monitor acceptance and refusal of EPSDT services, whether eligible Members are receiving the recommended health assessments and all necessary diagnosis and treatment, including EPSDT Special Services when needed.		Full	The Member Identification /Services Tracking Tools document describes the Member Profile and the Clinical Practice Registry (CPR) is used by staff and providers to identify members and care opportunities. These systems monitor compliance with	

Final Report 9/5/2014

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			EPSDT requirements including the periodicity schedule. The CPR is used by the care management team to develop plans of care and remind members of preventive health services. The CPR is updated daily with claims histories, diagnoses, utilization data, and service history. A screenshot of a sample CPR was submitted as evidence. During the second year of operation, the Member Profile will be enhanced with HEDIS indicators to alert staff to needed services. Member profiles that are shared with providers identify members with gaps (e.g., due/overdue for services). Using these profiles, providers may identify members who have refused services, however this information is not reported to the MCO or tracked. Members that have refused services will remain in the reports as members with gaps.	
H. Establish and maintain an effective and on-going Member Services case management function for eligible members and their families to provide education and counseling with regard to Member compliance with prescribed treatment programs and compliance with EPSDT appointments. This function shall assist eligible Members or their families in obtaining sufficient information so they can make medically informed decisions about their health care, provide support services including transportation and scheduling assistance to EPSDT services, and follow up with eligible Members and their families when recommended assessments and treatment are not received.		Full	The document 'RR CM Policy and Procedure' reveals the plan uses a trigger list of conditions to identify members for care management. The care manager becomes the point of contact to coordinate care between PCPs and specialists. Individuals with special health care needs are eligible for high risk care management programs. The stratification of enrollment in care management is based on predictive risk scoring.	

Final Report 9/5/2014

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			Report 24 describes the role of the EPSDT Coordinator to outreach members that are overdue for services. An annual brochure is sent as a reminder for well child visits. Care managers identify gaps in care using Dashboards in Care Advance, a care management documentation system. Managers use the Dashboard to guide member education, coordination of visits, and to address barriers to care. Through the Provider Clinical Engagement Initiative, PCPs can use CPR to identify members due for EPSDT visits.	
I. Maintain a consolidated record for each eligible member, including reports of informing about EPSDT, information received from other providers and dates of contact regarding appointments and rescheduling when necessary for EPSDT screening, recommended diagnostic or treatment services and follow-up with referral compliance and reports from referral physicians or providers.		Full	The Well Child document shows a screen shot of the Member Profile where PCP name and contact information is listed along with number of claims made by the PCP and Expanded Diagnosis Clusters showing the number of preventive care claims. Report 24 describes the role of the EPSDT Coordinator to outreach members that are overdue for services. Care managers identify gaps in care using Dashboards in Care Advance, a care management documentation system. Managers use the Dashboard to guide member education, coordination of visits, and to address barriers to care. Through the Provider Clinical Engagement Initiative, PCPs can use CPR to identify members due for EPSDT	

Final Report 9/5/2014

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			visits.	
J. Establish and maintain a protocol for coordination of physical health services and Behavioral Health Services for eligible members with behavioral health or developmentally disabling conditions.		Full	UM 93.13 is a Beacon Health Strategies policy and procedure demonstrating the process of collaboration and referral between medical and behavioral health services. Beacon is the vendor who provides behavioral health services for the plan's membership. The P/P indicates that Beacon staff is to contact Humana CareSource medical care management team about patients with frequent emergency department utilization, those needing medical assessment outside of the scope of Beacon's services, and/or those requiring assistance with arranging medical services. Humana CareSource clinical staff will remain involved until it is mutually determined by Beacon and the plan that the member is stable. Beacon assures of timely notification to Humana CareSource once a case is closed. The document 'RR CM Policy and Procedure' describes a "no wrong door" approach to care management where the plan provides 24 hour care management assistance referred from any source. The Coordination of PH/BH services document identifies specialized programming for PH/BH services with a utilization management approach to the "whole person" and "whole system". Daily	

Final Report 9/5/2014

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			care conferences attended by members of the clinical team are organized to foster collaboration with Beacon and coordinate care. Sample PH/BH conference notes were provided onsite. The Preventive Health EPSDT and ISHCN document states that the plan has a full-time BH manager and Health Services Manager to oversee the integration of BH and PH services.	
Coordination procedures shall be established for other services needed by eligible members that are outside the usual scope of Contractor services. Examples include early intervention services for infants and toddlers with disabilities, services for students with disabilities included in the child's individual education plan at school, WIC, Head Start, Department for Community Based Services, etc.		Full	The Coordination of PH/BH services document describes the collaborative effort of the plan with community agencies involved in Early Intervention (EI) Services. The plan attends regular meetings with the Department of Community Based Services (DCBS), and its liaisons in targeted services areas, performs needs assessment with the Health Services Director and the Commission for Children with Special Health Care Needs (CSHCN). Community Education representatives met with WIC, Head Start, Family Resources and Youth Coordinators in schools to provide member education. The plan has also developed a Community Resource Share Point site to store information on community resources for staff. According to the Preventive Health EPSDT and ISHCN document, the plan provides outreach to school based clinics to	

Final Report 9/5/2014

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			coordinate and provide care for members. The plan partners with community health centers (CHCs) who offer dental services in order to maintain a member to provider ratio of 1500:1. Dental care is promoted through member education and outreach using mailings and face to face interactions. Educational materials include a welcome packet, newsletters, electronic messaging, health care links, and a Find-A Doctor directory.	
K. Participate in any state or federally required chart audit or quality assurance study.		Full	Humana CareSource was new to KY Medicaid in 2013. The MCO's first participation with a chart audit/quality assurance study was the IPRO EPSDT validation study that began in November 2013.	
L. Maintain an effective education/ information program for health professionals on EPSDT compliance (including changes in state or federal requirements or guidelines). At a minimum, training shall be provided concerning the components of an EPSDT assessment, EPSDT Special Services, and emerging health status issues among Members which should be addressed as part of EPSDT services to all appropriate staff and Providers, including medical residents and specialists delivering EPSDT services. In addition, training shall be provided concerning physical assessment procedures for nurse practitioners, registered nurses and physician assistants who provide EPSDT screening services.		Full	EPSDT Clinical Guidelines website and links, the Winter Provider Newsletter, the Provider Manual, the EPSDT Provider Portal training, and the provider section of the general plan website were submitted by the plan as evidence of their educational program to providers on EPSDT compliance. These items provide the components of the EPSDT program, eligibility rules, appropriate ages for screenings and visits, billing/claims guidance, and how to make referrals for EPSDT special services. The Provider Site Visit form also indicates that education on the periodicity schedule is a part of the onsite visits by the Provider	

Final Report 9/5/2014

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			Representative.	
M. Submit Encounter Record for each EPSDT service provided according to requirements provided by the Department, including use of specified EPSDT procedure codes and referral codes. Submit quarterly and annual reports on EPSDT services including the current Form CMS-416.		Full	Annual CMS 416 Form was submitted to DMS on March 15, 2014. A copy of the report was provided during the onsite review. Sample encounter data can be viewed in the EPSDT Tracking and Well Child documents. Member-specific encounters related to EPSDT services are provided in the MCO's encounter data submissions.	
N. Provide an EPSDT Coordinator staff function with adequate staff or subcontract personnel to serve the Contractor's enrollment or projected enrollment.		Full	The job description of the EPSDT Coordinator was provided. This person is responsible for telephonic outreach, education on benefits and follow-up with the member about future appointments. The Coordinator reports to the Health Services Manager.	
22.1 Required Functions				
L. Arranging for and assisting with scheduling EPSDT Services in conformance with federal law governing EPSDT for persons under the age of 21 years.		Full	The document 'RR CM Policy and Procedure' details the role of the Care Manager as an additional level of support and monitoring for members needing EPSDT/preventive services. These Managers also outreach to new members to conduct health screening assessments via phone, mailings, or in person visits within 90 days of enrollment. This is especially true for members with special health care	

Final Report 9/5/2014

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			needs. The plan uses a trigger list of conditions to identify members for care management. The care manager becomes the point of contact to coordinate care between PCPs and specialists. Individuals with special health care needs are eligible for high risk care management programs. The stratification of enrollment in care management is based on predictive risk scoring. Report 24 describes the role of the EPSDT Coordinator to outreach members that are overdue for services. An annual brochure is sent as a reminder for well child visits. Care managers identify gaps in care using Dashboards in Care Advance, a care management documentation system. Managers use the Dashboard to guide member education, coordination of visits, and to address barriers to care. Through the Provider Clinical Engagement Initiative, PCPs can use CPR to identify members due for EPSDT visits. The Provider Manual indicates that PCPs are also responsible for serving as an EPSDT source and coordinating care.	
37.9 EPSDT Reports				
The Contractor shall submit Encounter Records to the Department's Fiscal Agent for each Member who receives EPSDT Services. This Encounter Record shall be completed according to the requirements provided by the Department,		Full	Annual CMS 416 Form was recently submitted to DMS. The plan submitted the 4th Quarter Report	

Final Report 9/5/2014

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
including use of specified EPSDT procedure codes and referral codes. Annually the Contractor shall submit a report on EPSDT activities, utilization and services and the current Form CMS-416 to the Department.			on EPSDT activities, utilization and services. Sample encounter data can be viewed in the EPSDT Tracking and Well Child documents. Member-specific encounters related to EPSDT services are provided in the MCO's encounter data submissions.	

KY EQRO ANNUAL REVIEW
March 2014
Period of Review: January 1, 2013 – December 31, 2013
MCO: Humana CareSource

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	18	2	0	0
Total Points	54	4	0	0

Overall Compliance Determination:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Range	**3.0**	**2.0 – 2.99**	**1.0 – 1.99**	**0 – 0.99**
Points Average		**2.90**		

As part of the review IPRO assessed the MCO's implementation of any actions proposed by the MCO in response to last year's findings. It should be noted that deficiencies previously identified that continue to be deficient in the current review may adversely affect the scoring of a requirement.

Reviewer Decision:

Full Compliance	MCO has met or exceeded requirements
Substantial Compliance	MCO has met most requirements but may be deficient in a small number of areas
Minimal Compliance	MCO has met some requirements but has significant deficiencies requiring corrective action
Non- Compliance	MCO has not met the requirements
Not Applicable (NA)	Statement does not require a review decision; for reviewer information purposes

Shading of Review Determination Column Only=Not subject to review, e.g., header, DMS responsibility
Shading of Columns for Review Determination, Comments and Health Plan's and DMS's Responses and Plan of Action=Not subject to review for the current review year, e.g., standard deemed due to full compliance achieved during prior review

Final Report 9/5/2014

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
Suggested Evidence

Documents

Policies/procedures for:

- EPSDT services
- Identification of members requiring EPSDT special services
- Education/information program for health professionals
- EPSDT provider requirements
- Coordination of physical health services and behavioral health services
- Coordination of other services, e.g., early intervention services

EPSDT member/provider ratio and case management ratio for EPSDT children with special needs
Evidence of communication of required EPSDT information with eligible members and families
EPSDT Coordinator position description
Description of tracking system to monitor acceptance and refusal of EPSDT services
Process for monitoring compliance with EPSDT services requirements including periodicity schedule
Evidence of case management function providing education and counseling for patient compliance
Process for ensuring follow-up evaluation, referral and treatment in response to EPSDT screening results
Linkage agreements between MCO providers and behavioral health providers to assure provision of EPSDT services
Copies of practitioner training materials and other educational/informational materials and attendance records
Process for calculating EPSDT participation and screening rates including quality control measures
Evidence of submission of EPSDT Encounter Records, including special EPSDT procedure codes and referral codes

File Review

Sample of UM and member and provider appeals related to EPSDT services selected by the EQRO

Reports

EPSDT reports (quarterly and annual 416 reports)
Annual EPSDT report of EPSDT activities, utilization and services

KY EQRO ANNUAL REVIEW
March 2014
Period of Review: January 1, 2013 – December 31, 2013
MCO: Humana CareSource

Final Report 9/5/2014

Quality Assessment and Performance Improvement: Structure and Operations – Delegated Services *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.230)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
5.3 Delegations of Authority			**General Recommendation for Humana CareSource:** Policies, procedures, reports and documents should be consistent with regard to branding/MCO name and specific to Kentucky Medicaid. The full MCO name, Humana CareSource, should be used consistently.	Humana-CareSource is in the process of reviewing policies, procedures, reports, and documents to ensure branding consistency with the "Humana-CareSource" name and logo. Additionally, we are reviewing all policies and procedures to ensure they are Kentucky Medicaid specific.
The Contractor shall oversee and remain accountable for any functions and responsibilities that it delegates to any Subcontractor. In addition to the provision set forth in Subcontracts, Contractor agrees to the following provisions.			Humana contracts with fourteen (14) subcontractors which include: Appalachian Regional Healthcare (date of initial contract: 9/4/2007) – provides credentialing services Ashland Area Health Alliance (date of initial contract: 1/1/2006) - provides credentialing services Beacon Health Strategies LLC (date of initial contract: 1/1/2013) - provides credentialing services Block Vision, Inc. (date of initial contract: 1/1/2013) - provides credentialing services Center Care/Commonwealth Health Corporation (date of initial contract: 6/21/2002) - provides credentialing services	

Final Report 9/5/2014

Quality Assessment and Performance Improvement: Structure and Operations – Delegated Services (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.230)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			Cooperative Care (date of initial contract: 6/21/2001) - provides credentialing services Deaconess Health Plans (date of initial contract: 1/12/2006) - provides credentialing services Healthways Whole Health Networks (date of initial contract: 1/1/2004) - provides credentialing services Managed Care of North America Dental (MCNA Dental) (date of initial contract: 3/13/2013) - provides credentialing services OrthoNet (date of initial contract: 1/14/2008) - provides credentialing services Trover Clinic (date of initial contract: 10/8/2001) - provides credentialing services University of Kentucky College of Medicine (date of initial contract: 11/1/2001) - provides credentialing services University of Louisville Physicians (date of initial contract: 6/13/2008) - provides credentialing services	

Final Report 9/5/2014

Quality Assessment and Performance Improvement: Structure and Operations – Delegated Services (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.230)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			CareSource Management Group Co. (date of initial contract: 11/1/2012) - provides services related to claims, UM, grievances and appeals, complex case management and disease management Service Agreements that were provided for CareSource Management Group Co., Beacon Health Strategies LLC and MCNA Dental are thorough and address all requirements During the onsite visit, the MCO advised that Service Agreements were not available as the following subcontractors are contracted through the State: Appalachian, Ashland, Block Vision, Center Car, Cooperative Care, Deaconess, Healthways, OrthoNet, Trover, University of Kentucky and University of Louisville.	
A. There shall be a written agreement that specifies the delegated activities and reporting responsibilities of the Subcontractor and provides for revocation of the delegation or imposition of other sanctions if the Subcontractor's performance is inadequate.		Full	This requirement is addressed in the Delegation Policy under the sub-policy section entitled Delegation Services Addendum and Attachments. This requirement is communicated to the subcontractors through the written delegation agreement.	
B. Before any delegation, the Contractor shall evaluate the prospective subcontractor's ability to perform the		Full	This requirement is addressed in the Delegation Policy under the sub-policy	

Final Report 9/5/2014

Quality Assessment and Performance Improvement: Structure and Operations – Delegated Services (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.230)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
activities to be delegated.			section entitled Pre-Delegation Audits. Pre-delegation audits were provided for: Beacon Health Strategies – audit performed on 1/2/2013 (score: 100%) MCNA Dental (date of contract 3/13/2013) – Pre-delegation audit was completed December 2012. The MCO advised the annual oversight audit is scheduled for January 2014.	
C. The Contractor shall monitor the Subcontractor's performance on an ongoing basis and subject the Subcontractor to a formal review at least once a year.		Full	This requirement is addressed in the Vendor Risk and Oversight Policy – Delegation Oversight Committee Policy (VRO-01) and the Vendor Management Delegation Oversight Policy (VRO-02). Performance is monitored on an ongoing basis by means of a weekly Market Operations Meeting, monthly tracking of metrics via a dashboard, bi-monthly Compliance Committee Meetings as well as the Annual Review. This requirement is communicated to the subcontractors through the written delegation agreement. Documentation of a comprehensive Annual Review was provided for all of the subcontractors except those whose contracts began during the period of review.	

Final Report 9/5/2014

Quality Assessment and Performance Improvement: Structure and Operations – Delegated Services (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.230)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
D. If the Contractor identifies deficiencies or areas for improvement, the Contractor and the Subcontractor shall take corrective action.		Full	This requirement is addressed in the Vendor Risk and Oversight Policy – Delegation Oversight Committee Policy (VRO-01), the Vendor Management Delegation Oversight Policy (VRO-02) and the MCO's Delegation Policy. This requirement is communicated to the subcontractors through the written delegation agreement. Areas of deficiency were identified during annual audits and CAPs were given to Ashland Area Health Alliance, Trover Clinic and to CareSource Management Group Co.	
E. If the Contractor delegates selection of providers to another entity, the Contractor retains the right to approve, suspend, or terminate any provider selected by that Subcontractor.		Full	This requirement is addressed in the Delegation Policy under the sub-policy section entitled Delegation Services Addendum and Attachments. This requirement is communicated to the subcontractors through the written delegation agreement and is monitored through the Delegation Oversight Committee.	
F. The Contractor shall assure that the Subcontractor is in compliance with the requirement in 42 CFR 438.		Full	This requirement is addressed in the Vendor Risk and Oversight Policy – Delegation Oversight Committee Policy (VRO-01) and the Vendor Management Delegation Oversight Policy (VRO-02).	

Final Report 9/5/2014

Quality Assessment and Performance Improvement: Structure and Operations – Delegated Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 438.230)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
7.1 Subcontractor Indemnity				
Except as otherwise provided in this Contract, all Subcontracts between the Contractor and its Subcontractors, shall contain an agreement by the Subcontractor to indemnify, defend and hold harmless the Commonwealth, its officers, agents, and employees, and each and every Member from any liability whatsoever arising in connection with this Contract for the payment of any debt of or the fulfillment of any obligation of the Subcontractor.		Full	This requirement is addressed and communicated to the subcontractors in each subcontractor's Delegation Services Addendum as well as in the Services Agreements.	
Each such Subcontractor shall further covenant and agree that in the event of a breach of the Subcontract by the Contractor, termination of the Subcontract, or insolvency of the Contractor, each Subcontractor shall provide all services and fulfill all of its obligations pursuant to the Subcontract for the remainder of any month for which the Department has made payments to the Contractor, and shall fulfill all of its obligations respecting the transfer of Members to other Providers, including record maintenance, access and reporting requirements all such covenants, agreements, and obligations of which shall survive the termination of this Contract and any Subcontract.		Full	This requirement is addressed and communicated to the subcontractors in each subcontractor's Delegation Services Addendum as well as in the Services Agreements.	
7.2 Requirements				
All Subcontractors must be eligible for participation in the Medicaid program as applicable. The Contractor may, with the approval of the Department, enter into Subcontracts for the provision of various Covered Services to Members or other services that involve risk-sharing, medical management, or otherwise interact with a Member. Each such Subcontract and any		Full	This requirement is addressed in the Vendor Risk and Oversight Policy – Delegation Oversight Policy (VRO-02). The MCO's Delegation Policy addresses the requirement that each subcontract and amendment be in writing and	

Final Report 9/5/2014

Quality Assessment and Performance Improvement: Structure and Operations – Delegated Services (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.230)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
amendment to such Subcontract shall be in writing, and in form and content approved by the Department. The Contractor shall submit for review to the Department a template of each type of such Subcontract referenced herein. The Department may approve, approve with modification, or reject the templates if they do not satisfy the requirements of this Contract. In determining whether the Department will impose conditions or limitations on its approval of a Subcontract, the Department may consider such factors as it deems appropriate to protect the Commonwealth and Members, including but not limited to, the proposed Subcontractor's past performance. In the event the Department has not approved a Subcontract referenced herein prior to its scheduled effective date, Contractor agrees to execute said Subcontract contingent upon receiving the Department's approval. No Subcontract shall in any way relieve the Contractor of any responsibility for the performance of its duties pursuant to this Contract. The Contractor shall notify the Department in writing of the status of all Subcontractors on a quarterly basis and of the termination of any approved Subcontract within ten (10) days following termination.			approved by the Department. The Delegation Policy also provides each type of template used. During the onsite review, Humana CareSource advised no subcontractors have been terminated. The MCO would notify DMS within 10 days if a termination occurred.	
The Department's subcontract review shall assure that all Subcontracts:				
A. Identify the population covered by the Subcontract;		Full	This requirement is addressed in the Service Agreement and Delegation Services Addendum.	
B. Specify the amount, duration and scope of services to be provided by the Subcontractor;		Full	This requirement is addressed in the Service Agreement and Delegation	

Final Report 9/5/2014

Quality Assessment and Performance Improvement: Structure and Operations – Delegated Services (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.230)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			Services Addendum.	
C. Specify procedures and criteria for extension, renegotiation, and termination;		Full	This requirement is addressed in the Service Agreement and Delegation Services Addendum.	
D. Specify that Subcontractors use only Medicaid providers in accordance with this Contract;		Full	This requirement is addressed in the Service Agreement and Delegation Services Addendum.	
E. Make full disclosure of the method of compensation or other consideration to be received from the Contractor;		Full	This requirement is addressed in the Service Agreement and Delegation Services Addendum.	
F. Provide for monitoring by the Contractor of the quality of services rendered to Members in accordance with the terms of this Contract;		Full	This requirement is addressed in the Service Agreement and the Delegation Services Addendum.	
G. Contain no provision that provides incentives, monetary or otherwise, for the withholding from Members of Medically Necessary Covered Services;		Full	This requirement is addressed in the Service Agreement and the Delegation Services Addendum.	
H. Contain a prohibition on assignment, or on any further subcontracting, without the prior written consent of the Department;		Full	This requirement is addressed in the Service Agreement and the Delegation Services Addendum.	
I. Contain an explicit provision that the Commonwealth is the intended third-party beneficiary of the Subcontract and, as such, the Commonwealth is entitled to all remedies entitled to third-party beneficiaries under law;		Full	This requirement is addressed in the Service Agreement.	
J. Specify that Subcontractor where applicable, agrees to submit Encounter Records in the format specified by the Department so that the Contractor can meet the Department's specifications required by this Contract;		Full	This requirement is addressed in the Service Agreement.	

Final Report 9/5/2014

Quality Assessment and Performance Improvement: Structure and Operations – Delegated Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 438.230)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
K. Incorporate all provisions of this Contract to the fullest extent applicable to the service or activity delegated pursuant to the Subcontract, including, without limitation,		Full	This requirement is addressed in the Service Agreement.	
(1) the obligation to comply with all applicable federal and Commonwealth law and regulations, including, but not limited to, KRS 205:8451-8483, all rules, policies and procedures of Finance and the Department, and all standards governing the provision of Covered Services and information to Members,		Full	This requirement is addressed in the Service Agreement.	
(2) all QAPI requirements,		Full	This requirement is addressed in the Service Agreement.	
(3) all record keeping and reporting requirements,		Full	This requirement is addressed in the Service Agreement.	
(4) all obligations to maintain the confidentiality of information,		Full	This requirement is addressed in the Service Agreement.	
(5) all rights of Finance, the Department, the Office of the Inspector General, the Attorney General, Auditor of Public Accounts and other authorized federal and Commonwealth agents to inspect, investigate, monitor and audit operations,		Full	This requirement is addressed in the Service Agreement.	
(6) all indemnification and insurance requirements, and		Full	This requirement is addressed in the Service Agreement.	
(7) all obligations upon termination;		Full	This requirement is addressed in the Service Agreement.	
L. Provide for Contractor to monitor the Subcontractor's performance on an ongoing basis including those with accreditation: the frequency and method of reporting		Full	This requirement is addressed in the Services Agreement.	

Final Report 9/5/2014

Quality Assessment and Performance Improvement: Structure and Operations – Delegated Services (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.230)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
to the Contractor; the process by which the Contractor evaluates the Subcontractor's performance; and subjecting it to formal review according to a periodic schedule consistent with industry standards, but no less than annually;				
M. A Subcontractor with NCQA/URAC or other national accreditation shall provide the Contractor with a copy of its' current certificate of accreditation together with a copy of the survey report.		Full	This requirement is addressed in the Services Agreement.	
N. Provide a process for the Subcontractor to identify deficiencies or areas of improvement, and any necessary corrective action.		Full	This requirement is addressed in the Services Agreement.	
O. The remedies up to, and including, revocation of the subcontract available to the Contractor if the Subcontractor does not fulfill its obligations.		Full	This requirement is addressed in the Services Agreement.	
P. Contain provisions that suspected fraud and abuse be reported to the contractor.		Full	This requirement is addressed in the Services Agreement.	
Section 7.2 requirements would be applicable to Subcontractors characterized as Providers/Risk Arrangements including, but not limited to, physicians, hospitals, ancillary providers, IPAs/PHOs, Provider Networks, and Vision Care, Dental and Behavior Health Services; and to those who interact and assist Members including, but not limited to, Radiology Benefit Manager, Disease Management/Case Management, Health Risk Assessments, Pre-Certification Services, PBM, Recoveries, Translation Services and 24-hour Section 7.2 requirements shall not apply to Subcontracts for administrative services or other vendor contracts that do not impact Members.		Full	This requirement is addressed in the Services Agreement.	

Final Report 9/5/2014

Quality Assessment and Performance Improvement: Structure and Operations – Delegated Services (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.230)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
7.3 Disclosure of Subcontractors				
The Contractor shall inform the Department of any Subcontractor providing Covered Services which engages another Subcontractor in any transaction or series of transactions, in performance of any term of this Contract, which in one fiscal year exceeds the lesser of $250,000 or five percent (5%) of the Subcontractor's operating expense.		Full	This requirement is addressed in the Services Agreement.	
7.4 Remedies				
Finance shall have the right to invoke against any Subcontractor any remedy set forth in this Contract, including the right to require the termination of any Subcontract, for each and every reason for which it may invoke such a remedy against the Contractor or require the termination of this Contract.				

Final Report 9/5/2014

Quality Assessment and Performance Improvement: Structure and Operations – Delegated Services

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	34	0	0	0
Total Points	102	0	0	0

Overall Compliance Determination:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Range	**3.0**	**2.0 – 2.99**	**1.0 – 1.99**	**0 – 0.99**
Points Average	**3.0**			

As part of the review IPRO assessed the MCO's implementation of any actions proposed by the MCO in response to last year's findings. It should be noted that deficiencies previously identified that continue to be deficient in the current review may adversely affect the scoring of a requirement.

Reviewer Decision:

Full Compliance	MCO has met or exceeded requirements
Substantial Compliance	MCO has met most requirements but may be deficient in a small number of areas
Minimal Compliance	MCO has met some requirements but has significant deficiencies requiring corrective action
Non- Compliance	MCO has not met the requirements
Not Applicable (NA)	Statement does not require a review decision; for reviewer information purposes

Shading of Review Determination Column Only=Not subject to review, e.g., header, DMS responsibility
Shading of Columns for Review Determination, Comments and Health Plan's and DMS's Responses and Plan of Action=Not subject to review for the current review year, e.g., standard deemed due to full compliance achieved during prior review

Final Report 9/5/2014

Quality Assessment and Performance Improvement: Structure and Operations – Delegated Services

Suggested Evidence

Documents

List of subcontractors including type(s) of services provided and date of initial delegation
Contract with each subcontractor
Accreditation certificate and report for each subcontractor
Policies and procedures for subcontractor oversight
Subcontractor Oversight Committee description, meeting agendas and minutes
Documentation of ongoing oversight of subcontractors including follow-up
List of subcontractors terminated during the period of review
Evidence of DMS notification of all new subcontractors and terminated subcontractors
Evidence of disclosure of subcontractor activity to DMS

Reports

Pre-delegation evaluation report for new subcontractors
Periodic, formal evaluation reports for each subcontractor, including those with accreditation
Subcontractor certificate of accreditation and survey report

KY EQRO ANNUAL REVIEW
March 2014
Period of Review: January 1, 2013 – December 31, 2013
MCO: Humana CareSource

Final Report 9/5/2014

Quality Assessment and Performance Improvement: Health Information Systems (HIS) *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.242)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
17.1 Encounter Data Submission			**General Recommendation for Humana CareSource:** Policies, procedures, reports and documents should be consistent with regard to branding/MCO name and specific to Kentucky Medicaid. The full MCO name, Humana CareSource, should be used consistently.	Humana-CareSource is in the process of reviewing policies, procedures, reports, and documents to ensure branding consistency with the "Humana-CareSource" name and logo. Additionally, we are reviewing all policies and procedures to ensure they are Kentucky Medicaid specific.
The Contractor shall have a computer and data processing system sufficient to accurately produce the data, reports and Encounter Record set in formats and timelines prescribed by the Department as defined in the Contract.		Full	Humana CareSource uses Trizetto's Medical Data Express (MDE) Encounter Pro software for the encounter file creation process This is addressed in document Trizetto Encounter Product Sheet. There is also a detailed process flow chart in a Visio document titled 'Visio-Encounters Submission Kentucky'.	
The system shall be capable of following or tracing an Encounter within its system using a unique Encounter Record identification number for each Encounter.		Full	Addressed in document - ClaimsXRef. The number identified in a red box preceded by the string of characters 'CLM' is the unique identifier used to submit encounters to DMS.	
At a minimum, the Contractor shall be required to electronically provide Encounter Record to the Department, on a weekly schedule.		Full	Humana CareSource provided MCO Report# 64, Encounter Data Summary reports demonstrating weekly submissions of encounter records to the Department.	
Encounter Record must follow the format, data elements and method of transmission specified by the Department.		Full	The Visio flowchart shows that files are submitted in HIPAA compliant format and report#64 addresses submission to DMS.	
All changes to edits and processing requirements due to Federal or State law changes shall be provided to the Contractor in writing no less than sixty (60) working days prior to implementation, whenever possible.				

Final Report 9/5/2014

Quality Assessment and Performance Improvement: Health Information Systems (HIS) *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.242)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
The Contractor shall submit electronic test data files as required by the Department in the format referenced in this Contract and as specified by the Department.		Not Applicable	No evidence provided that the Department has requested test data files.	
The electronic test files are subject to Department review and approval before production of data.				
The Contractor shall have the capacity to track and report on all Erred Encounter Records.		Full	Report #64, Encounter Data Summary reports demonstrates weekly submissions of encounter records to the Department. On a weekly basis the MCO tracks and reports rejected encounters. Visio-Encounters submission Kentucky details the response file load and analysis process which addresses rejected/erred records.	
The Contractor shall be required to use procedure codes, diagnosis codes and other codes used for reporting Encounter Record in accordance with guidelines defined by the Department in writing. The Contractor must also use appropriate NPI/Provider numbers for Encounter Records as directed by the Department.		Full	The flowchart 'Visio-Encounters Submission Kentucky' describes the HIPAA validation and gateway as part of the systems infrastructure.	
All subcontracts with Providers or other vendors of service must have provisions requiring that Encounter Record is reported/submitted in an accurate and timely fashion.		Full	Addressed in provider and subcontractor agreements. Claims payment policies are available on the Humana CareSource website for provider reference.	
The Contractor shall specify to the Department the name of the primary contract person assigned responsibility for submitting and correcting Encounter Record, and a secondary contact person in the event the primary contract person is not available.		Full	Humana CareSource submitted a copy of an email sent to DMS with the names of the encounter data staff.	
17.2 Technical Workgroup				

Final Report 9/5/2014

Quality Assessment and Performance Improvement: Health Information Systems (HIS) *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.242)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
The Contractor shall assign staff to participate in the Encounter Technical Workgroup periodically scheduled by the Department. The workgroup's purpose is to enhance the data submission requirements and improve the accuracy, quality and completeness of the Encounter Record.		Full	Per Humana CareSource's response, the meetings are scheduled for Thursdays but are frequently cancelled. Humana CareSource has two representatives attending either in-person or by conference line. Recently the State has begun taking minutes of these meetings.	
18 Kentucky Health Information Exchange (KHIE)				
The Contractor shall provide all adjudicated Claims data within twenty-four (24) hours of final claim adjudication in support of KHIE. The Contractor shall provide the KHIE with all clinical data as soon as it is available. The Contractor will also share with the KHIE any Member patient clinical data.		Not Applicable	The requirement to submit to Kentucky Health Information Exchange (KHIE) was suspended by KDMS in March 2013.	
The PCPs in the Contractor's network shall be required to connect to KHIE within one (1) year of the effective date of the contract with the Contractor or other schedule as determined by the Department. Furthermore, the Contractor shall encourage all providers in their Network to establish connectivity with the KHIE.		Not Applicable	The requirement to submit to KHIE was suspended by KDMS in March 2013. **Recommendation to Humana CareSource** Although the requirements were suspended, the MCO should make a good faith effort to encourage all providers in their network to establish connectivity with the KHIE.	Although the contract requirements were suspended in March of 2013, Humana CareSource is taking the suggestion to make a good faith effort to encourage all providers in their network to establish connectivity with the KHIE under advisement."
29.1 Claims Payments				
In accordance with the Balanced Budget Act (BBA) Section 4708, the Contractor shall implement Claims payment procedures that ensure 90% of all Provider Claims for which no further written information or substantiation is required in order to make payment are paid or denied within thirty (30) days of the date of receipt of such Claims and that 99% of all Claims are		Full	MCO Report #53, Prompt Pay Report for Q2 2013 demonstrates compliance with the 30 days standard.	

Final Report 9/5/2014

Quality Assessment and Performance Improvement: Health Information Systems (HIS) *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulations 438.242)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
processed within ninety (90) days of the date of receipt of such Claims.				
In addition, the Contractor shall comply with the Prompt-Pay statute, codified within KRS 304.17A-700-730, as may be amended, and KRS 205.593, and KRS 304.14-135 and 99-123, as may be amended.		Full	The Prompt Pay Report for Q2 2013 demonstrates compliance.	

Quality Assessment and Performance Improvement: Health Information Systems

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	11	0	0	0
Total Points	33	0	0	0

Overall Compliance Determination:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Range	**3.0**	**2.0 – 2.99**	**1.0 – 1.99**	**0 – 0.99**
Points Average	3.0			

As part of the review IPRO assessed the MCO's implementation of any actions proposed by the MCO in response to last year's findings. It should be noted that deficiencies previously identified that continue to be deficient in the current review may adversely affect the scoring of a requirement.

Reviewer Decision:

Full Compliance	MCO has met or exceeded requirements
Substantial Compliance	MCO has met most requirements but may be deficient in a small number of areas
Minimal Compliance	MCO has met some requirements but has significant deficiencies requiring corrective action
Non- Compliance	MCO has not met the requirements
Not Applicable	Statement does not require a review decision

Shading of Review Determination Column Only=Not subject to review, e.g., header, DMS responsibility
Shading of Columns for Review Determination, Comments and Health Plan's and DMS's Responses and Plan of Action=Not subject to review for the current review year, e.g., standard deemed due to full compliance achieved during prior review

Final Report 9/5/2014

Quality Assessment and Performance Improvement: Health Information Systems
Suggested Evidence

Documents

Policies/procedures for:

- Claims processing
- Claims payment
- Encounter data reporting

Process for verifying the accuracy and completeness of provider and vendor reported data
Process for screening data for completeness, logic and consistency
Evidence of timely and accurate reporting of encounter data to DMS
Process for monitoring compliance with claims payment timeliness requirements
Process for tracking and reporting erred encounter records
Evidence of participation in Encounter Technical workgroup
Method for meeting KHIE requirements
Status of efforts to have PCPs establish connectivity to KHIE

Reports

Timeliness of Claims Payment
Results of compliance monitoring for timeliness of claims payment and compliance with prompt pay statute
Internal quality measurement results related to accuracy and completeness of encounter data, including analysis and follow-up

KY EQRO ANNUAL REVIEW
March 2014
Period of Review: January 1, 2013 – December 31, 2013
MCO: Humana CareSource

Final Report 9/12/2014

Case Management/Care Coordination *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
2. Definitions			**General Recommendation for Humana CareSource:** Policies, procedures, reports and documents should be consistent with regard to branding/MCO name and specific to Kentucky Medicaid. The full MCO name, Humana CareSource, should be used consistently.	Humana-CareSource is in the process of reviewing policies, procedures, reports, and documents to ensure branding consistency with the "Humana-CareSource" name and logo. Additionally, we are reviewing all policies and procedures to ensure they are Kentucky Medicaid specific.
Care Coordination means the integration of all processes in response to a Member's needs and strengths to ensure the achievement of desired outcomes and the effectiveness of services.				
Care Management System includes a comprehensive assessment and care plan care coordination and case management services. This includes a set of processes that arrange, deliver, monitor and evaluate care, treatment and medical and social services to a member.				
Care Plan means written documentation of decisions made in advance of care provided, based on a Comprehensive Assessment of a Member's needs, preference and abilities, regarding how services will be provided. This includes establishing objectives with the Member and determining the most appropriate types, timing and supplier(s) of services. This is an ongoing activity as long as care is provided.				
Case Management is a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet the				

Final Report 9/12/2014

Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
client's health and human service needs. It is characterized by advocacy, communication, and resource management and promotes quality and cost-effective interventions and outcomes.				
Children with Special Health Care Needs means Members who have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type or amount that is beyond that required by children generally and who may be enrolled in a Children with Special Health Care Needs program operated by a local Title V funded Maternal and Child Health Program.				
CHIPRA means the Children's Health Insurance Program Reauthorization Act of 2009 which reauthorized the Children's Health Insurance Program (CHIP) under Title XXI of the Social Security Act. It assures that State is able to continue their existing program and expands insurance coverage to additional low-income, uninsured children.				
Comprehensive Assessment means the detailed assessment of the nature and cause of a person's specific conditions and needs as well as personal resources and abilities. This is generally performed by an individual or a team of specialists and may involve family, or other significant people. The assessment may be done in conjunction with care planning.				
34.2 Care Management System				
As part of the Care Management System, Contractor shall employ care coordinators and case managers to		Full	The 2013 Kentucky Care Management Model pp 8-10, 12-19 discusses the	

Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
arrange, assure delivery of, monitor and evaluate basic and comprehensive care, treatment and services to a Member.			potential members of the interdisciplinary team that work together to manage members' care in the various Care Management programs that are offered. The Member Handbook states "We have registered nurses, social workers and other outreach workers. They can work with you one-on-one to help coordinate your healthcare needs". Addressed in Provider Manual. Job ID CM-02430 RN Case and Disease Manager Job Description details the essential functions of the Care Coordination process.	
Members needing Care Management Services shall be identified through the health risk assessment, evaluation of Claims data, Physician referral or other mechanisms that may be utilized by the Contractor.		Full	P/P CM 21 Case Management – Care Management Policy and Procedure – KY section E.2 defines the process for identifying members that require Care Management services.	
The Contractor shall develop guidelines for Care Coordination that will be submitted to the Department for review and approval. The Contractor shall have approval from the Department for any subsequent changes prior to implementation of such changes.		Full	2013 Kentucky Care Management Model document discusses in detail the Care Management System processes.	
Care coordination shall be linked to other Contractor systems, such as QI, Member Services and Grievances.		Full	2013 Kentucky Care Management Model addresses Program Evaluation for QI monitoring & assessment, discusses	

Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			program evaluation utilizing tools such as member surveys, SF-12 survey and outcomes based quality and utilization indicators. The program is reviewed annually and as needed. A summary report is posted to the provider's website. A Quality Improvement Work Plan is created annually and submitted in writing for review and approval prior to implementing any changes to the program. Document titled "Evidence of Effectiveness of Case Management" measures includes organizational performance, member satisfaction, access to care, service performance and member expectations.	
34.3 Care Coordination				
The care coordinators and case managers will work together with the primary care providers as teams to provide appropriate services for Members.		Full	Addressed in P/P CM 21 Case Management - Care Management Policy and Procedure – Kentucky. The 2013 Kentucky Care Management Model pp 8-10, 12-19 discusses the potential members of the interdisciplinary team that work together to manage members' care in the various Care Management programs that are offered. Addressed in Member Handbook and Provider Manual.	

Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			Job ID CM-02430 RN Case and Disease Manager Job Description details the essential functions of the Care Coordination process.	
Care coordination is a process to assure that the physical and behavioral health needs of the Members are identified and services are facilitated and coordinated with all service providers, individual Members and family, if appropriate, and authorized by the Member.				
The Contractor shall identify the primary elements for care coordination and submit the plan to the Department for approval.		Full	Addressed in P/P CM 21 Case Management - Care Management Policy and Procedure – Kentucky.	
The Contractor shall identify a Member with special health care needs, including but not limited to Members identified in Member Services. A Member with special health care needs shall have a Comprehensive Assessment completed upon admission to a Care Management program. The Member will be referred to Care Management. Guidelines for referral to the appropriate care management programs shall be pre-approved by the Department. The guidelines will also include the criteria for development of Care Plans. The Care Plan shall include both appropriate medical, behavioral and social services and be consistent with the Primary Care Provider's clinical treatment plan and medical diagnosis.		Full	Addressed in P/P CM 21 Case Management - Care Management Policy and Procedure – Kentucky. The procedure addresses care plan development and how members are classified as low, medium or high risk in the Care Management program; the assessment process and member assignment to the appropriate Care Management program; the assessment process covers medical, behavioral & social components; there are provisions for contact and coordination with the PCP. P/P CM 22 – Case and Disease Management – Individuals with Special Health Care Needs (ISHCN) – KY addresses identification of ISHCN members.	

Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
The Contractor shall first complete a Care Coordination Assessment for these Members the elements of which shall comply with policies and procedures approved by the Department.		Full	Addressed in P/P CM 22 – Case and Disease Management – Individuals with Special Health Care Needs – KY. Care Coordination File Review 10 out of 10 cases reviewed included a comprehensive assessment completed upon admission to care management. Complex Case Management File Review 10 out of 10 cases reviewed included a comprehensive assessment.	
The Care Plan shall be developed in accordance with 42 CFR 438.208.		Substantial	Addressed in P/P CM 22. Care Coordination File Review 10 out of 10 cases reviewed included a care plan. 10 out of 10 files reviewed included identification of physical and behavioral health needs of the member and facilitation and coordination of services with all service providers, member and family, as appropriate. Complex Case Management File Review 10 out of 10 cases reviewed included a care plan. 9 out of 10 files reviewed included identification of physical and behavioral health needs of the member and facilitation and coordination of services with all service	Identification of physical and behavioral health needs of the member and facilitation and coordination of services with all service providers, member and family, as appropriate, will be added to the internal quality auditing process for case management files.

Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			providers, member and family, as appropriate. **Recommendation for Humana CareSource** Case management files should demonstrate coordination of services with all service providers, member and family, as needed.	
The Contractor shall develop and implement policies and procedures to ensure access to care coordination for all DCBS clients. The Contractor shall track, analyze, report, and when indicated, develop corrective action plans on indicators that measure utilization, access, complaints and grievances, and satisfaction with care and services specific to the DCBS population.		Minimal	P/P CM 22. 2013 Kentucky Care Management Model discusses program evaluation utilizing tools such as member surveys, SF-12 survey and outcomes based quality and utilization indicators. The program is reviewed annually and as needed. A summary report is posted to the provider's website. A Quality Improvement Work Plan is created annually and submitted in writing for review and approval prior to implementing any changes to the program. These activities are described for the overall care management population, not specifically for the Department of Community Based Services (DCBS) population. Utilization reports provided include inpatient and outpatient medical management key statistics for the Temporary Aid to Needy Families (TANF) and Aged, Blind and Disabled (ABD) populations. A draft quality measures report	HUMANACARESOURCE will develop a policy and procedure addressing tracking, analyzing, reporting and developing corrective action plans for indicators measuring utilization, access, complaints and grievances, and satisfaction with care and services for the DCBS population.

Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			includes HEDIS measures with a breakout for children with special health care needs. Reporting for access, complaints and grievances, and satisfaction for this population was not provided. **Recommendation for Humana CareSource** The MCO should establish policies/procedures for tracking, analyzing, reporting and developing corrective action plans for indicators measuring utilization, access, complaints and grievances, and satisfaction with care and services for the DCBS population. Evidence of reporting, analysis and follow-up should be included for EQRO review.	
Members, Member representatives and providers shall be provided information relating to care management services, including case management, and information on how to request and obtain these services.		Full	Member Handbook discusses care management services and the toll free number to call Care Management Support Services for information. Handbook also provides the Member Services phone number and the website www.CareSource.com/KY.	
35.1 Individuals with Special Health Care Needs (ISHCN)				
ISHCN are persons who have or are at high risk for chronic physical, developmental, behavioral, neurological, or emotional condition and who may require a broad range of primary, specialized medical, behavioral health, and/or related services. ISCHN may				

Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
have an increased need for healthcare or related services due to their respective conditions. The primary purpose of the definition is to identify these individuals so the Contractor can facilitate access to appropriate services.				
As per the requirement of 42 CFR 438.208, the Department has defined the following categories of individuals who shall be identified as ISHCN. The Contractor shall have written policies and procedures in place which govern how Members with these multiple and complex physical and behavioral health care needs are further identified.		Full	Addressed in P/P CM 22.	
The Contractor shall have an internal operational process, in accordance with policy and procedure, to target Members for the purpose of screening and identifying ISHCN's.		Full	Addressed in P/P CM 22.	
The Contractor shall assess each member identified as ISHCN in order to identify any ongoing special conditions that require a course of treatment or regular care monitoring. The assessment process shall use appropriate health professionals.		Full	Addressed in P/P CM 22 and P/P CM 21 Case Management - Care Management Policy and Procedure – Kentucky.	
The Contractor shall employ reasonable efforts to identify ISHCN's based on the following populations: Children in/or receiving Foster Care or adoption assistance; Blind/Disabled Children under age 19 and Related Populations eligible for SSI; Adults over the age of 65; Homeless (upon identification); individuals with chronic physical health illnesses; and individuals with chronic behavioral health illnesses.		Full	2013 Kentucky Care Management Model identifies classifications of members who require ISHCN care management. Also discusses the methods of identification and potential referral sources to the care management program.	

Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
The Contractor shall develop and distribute to ISHCN Members, caregivers, parents and/or legal guardians, information and materials specific to the needs of the member, as appropriate. This information shall include health educational material as appropriate to assist ISHCN and/or caregivers in understanding their chronic illness.		Full	2013 Kentucky Care Management Model discusses the 24/7 nurse advice line, the provider's educational resources that are available to members and providers including community, religious and government agencies\resources. The provider's website also provides a listing of resource and educational materials for member and provider access. Newsletters are also distributed to members. 2013 Quality Improvement Program Humana CareSource addresses member education. Provider Manual discusses member education resources. Member Handbook provides phone, website and email contact information and discusses the 24/7 nurse line as well as care management and outreach services. Addressed in P/P CM-10 Marketing – Material Development for Non-English Speaking and Special Needs Populations – "purpose of this policy is to ensure that marketing and member materials are available for non-English speaking and special needs populations."	
The Contractor shall have in place policies governing the		Full	P/P CM-22 defines the methodology for	

Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
mechanisms utilized to identify, screen, and assess individuals with special health care needs.			identifying ISHCN members. The screening and assessment process is reference in P/P CM-21 Case Management – Care Management Policy and Procedure – Kentucky. Policy notes that ISHCN members are eligible for enrollment in the high risk care management program.	
The Contractor will produce a treatment plan for enrollees with special health care needs who are determined through assessment to need a course of treatment or regular care monitoring.		Full	P/P CM 21 Case Management - Care Management Policy and Procedure – Kentucky. The assessment, treatment plan and care management for ISHCN members is addressed in this policy.	
The Contractor shall develop practice guidelines and other criteria that consider that needs of ISHCN and provide guidance in the provision of acute and chronic physical and behavioral health care services to this population.		Full	Addressed in P/P CM 21 Case Management - Care Management Policy and Procedure – Kentucky. The assessment, treatment plan and care management for ISHCN members is addressed in this policy. Needs of these members are addressed within care management under the High Risk/Complex Care portion of the policy. P/P QI-03 Quality Improvement – Development and Distribution of Preventative Health and Clinical Practice Guidelines. States "clinical practice guidelines for care of members with specific clinical circumstances, special needs or specific age ranges, are developed, adopted, reviewed and updated." 2013 Quality Improvement Program	

Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			Humana CareSource addresses clinical guidelines. Document titled "CPG" contains a provider website link which addresses clinical guidelines for specific conditions. https://www.caresource.com/providers/kentucky/member-care/clinical-guidelines/	
35.2 DCBS Protection and Department for Aging and Independent Living DAIL Protection and Permanency Clients				
Members who are adult guardianship clients or foster care children shall be identified as ISHCN and shall be enrolled in the Contractor through a service plan that will be completed on each such Member by DCBS and Department for Aging and Independent Living (DAIL) prior to being enrolled with the Contractor. The service plan will be completed by DCBS or DAIL and forwarded to the Contractor prior to Enrollment and will be used by DCBS and or DAIL and the Contractor to determine the individual's medical needs and identify the need for placement in case management. The Contractor shall be responsible for the ongoing care coordination of these members whether or not enrolled in case management to ensure access to needed social, community, medical and behavioral health services. A monthly report of Foster Care Cases shall be sent to Department thirty (30) days after the end of each month.		Substantial	Addressed in P/P CM 21 and P/P CM-22. Document titled "DCBS - Satisfaction Data for DCBS Population" indicates that the Meyers Group will conduct annual member satisfactions surveys. This process has not yet been completed, but is slated to be administered to the population in 2014. Document titled "Service Plans - Service Plans for DCBS and Department for Aging and Independent Living (DAIL) Members" states that the CM reviews and collaborates with the team on all services plans at a minimum of monthly and when changes in the plan occur. At this time, the Case Management documentation system Clinical Care Advance (CCA) team is identifying these members by case type for case manager dashboard upgrade. This will allow reports	As indicated at the time of the review, Humana-CareSource utilizes the member profile to identify all members, including DCBS members with care gaps (including age-appropriate well visits and EPSDT Services). Additionally all members are mailed the child and teen EPSDT brochures. These were submitted as documentation for the initial review. (RR KY MMED-78 and 79). An additional outreach was added in 2014. The EPSDT Coordinator makes outbound calls to members who are due or delinquent in their age-appropriate well visits and EPSDT services, which includes the DCBS members. Final Review Determination: No change in compliance level.

Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			to be initiated on all DCBS/DAIL members indicating the presence of service plans, dates of review and triggers for future review dates. The estimated completion date is Q1 2014. <u>DCBS Service Plan File Review</u> 20 out of the 20 files included ongoing care coordination to ensure access to needed social, community, medical and behavioral health services. <u>DCBS Claims File Review</u> 10 files were reviewed. 8/10 files demonstrated evidence of well visits and EPSDT services. For the 2 files without such evidence, no evidence of outreach was provided. 5 files showed evidence of need for physical health/behavioral health coordination and the files demonstrated provision of this coordination. 10/10 files demonstrated evidence of coordination with other service providers. **<u>Recommendation for Humana CareSource</u>** Humana CareSource should conduct ensure that outreach to DCBS members in need of age-appropriate well visits and EPSDT services.	The finding is based on the file review for DCBS Claims: 8/10 files demonstrated evidence of well visits and EPSDT services. For the 2 files without services/visits, no evidence of outreach was provided. There was no evidence provided of the outreach described for the two cases mentioned. General outreach is not sufficient for the file review. Member-specific documentation must be provided.

Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
35.3 Adult Guardianship Clients				
Upon Enrollment with the Contractor, each adult in Guardianship shall have a service plan prepared by DAIL. The service plan shall indicate DAIL level of responsibility for making medical decisions for each Member. If the service plan identifies the need for case management, the Contractor shall work with Guardianship staff and/or the Member, as appropriate, to develop a case management care plan.		Full	Addressed in P/P CM 21 and P/P CM-22. Per "DCBS" - Satisfaction Data for DCBS population, the Meyers Group will conduct annual member satisfactions surveys. This process has not yet been completed, but is slated to be administered to the population for 2014. Document titled "Service Plans - Service Plans for DCBS and DAIL Members" states that the CM reviews and collaborates with the team on all services plans at a minimum of monthly and when changes in the plan occur. At this time, the Case Management documentation system Clinical Care Advance (CCA) team is identifying these members by case type for case manager dashboard upgrade. This will allow reports to be initiated on all DCBS/DAIL members indicating the presence of service plans, dates of review and triggers for future review dates. The estimated completion date is Q1 2014.	
35.4 Children in Foster Care				
Upon Enrollment with the Contractor, each child in Foster Care shall have a service plan prepared by DCBS. DCBS shall forward a copy of the service plan to the Contractor on each newly enrolled Foster Care child. No		Substantial	Document titled "Service Plans - Service Plans for DCBS and DAIL Members" states that the CM reviews and collaborates with the team on all services plans at a minimum	Humana-CareSource believes they are in full compliance with this contract requirement. Humana-CareSource continually outreaches to DCBS for service

Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
less than monthly, DCBS staff shall meet with Contractor's staff to identify, discuss and resolve any health care issues and needs of the child as identified in the service plan. Examples of these issues include needed specialized Medicaid Covered Services, community services and whether the child's current primary and specialty care providers are enrolled in the Contractor's Network.			of monthly and when changes in the plan occur. At this time, the Case Management documentation system Clinical Care Advance (CCA) team is identifying these members by case type for case manager dashboard upgrade. This will allow reports to be initiated on all DCBS/DAIL members indicating the presence of service plans, dates of review and triggers for future review dates. The estimated completion date is Q1 2014. <u>DCBS Service Plan File Review</u> 17 out of 20 cases included a service plan. Of the 17 cases that did include a service plan, 16/17 cases indicated monthly meetings to identify, discuss, and resolve health care issues of the child. In one case, evidence of collaboration with DCBS was provided through October 2013 but then was not noted again until March 2014. **<u>Recommendation for Humana CareSource</u>** Humana should continue to outreach to DCBS for service plans for all DCBS members. Ongoing collaboration with DCBS should occur at least monthly as required.	plans for all DCBS members and will continue to do so. Per the contract, each child in Foster Care shall have a service plan prepared by DCBS. As Humana-CareSource must rely on the DCBS MCO Regional Liaisons and Case Workers to forward completed service plans to Humana-CareSource, the MCO can only encourage the receipt and work with DCBS to request those not received. As Humana-CareSource indicated during this audit, during 2013 Humana-CareSource had monthly meetings with DCBS Central Office Staff. In some cases, meetings were held on a weekly basis if there was an extremely challenging DCBS member and the need for collaborative efforts between Humana-CareSource, DCBS, CRP, BHDID, and DMS were identified. As indicated during the review, the Humana-CareSource had also began having monthly meetings with the DCBS Regional Liaisons to facilitate the receipt of service plans from DCBS case workers, discuss any issues and to coordinate activities for the DCBS members. Humana-CareSource believes this meets the contract intent of monthly meetings, as in many cases there are multiple DCBS/MCO meetings in any given month. As service plans are a standing agenda item at the monthly meetings with

Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
				DCBS, we believe we are actively pursuing the receipt of service plans and meeting this contract element fully. Final Review Determination: No change in compliance level. The finding is based on the file review results. There was a gap in communication/collaboration from October 2013 through March 2014 for one case. Monthly meetings were not evident during this time.
If DCBS service plan identifies the need for case management or DCBS staff requests case management for a Member, the foster parent and/or DCBS staff will work with Contractor's staff to develop a case management care plan.		Full	Addressed in P/P CM-21. DCBS Service Plan Review 20 out of 20 cases included coordination with foster parent and/or DCBS staff to develop a case management care plan.	
The Contractor will consult with DCBS staff before the development of a new case management care plan (on a newly identified health care issue) or modification of an existing case management care plan.		Full	Addressed in P/P CM-21 and document titled "Service Plans". DCBS Service Plan File Review 16 out of the 17 files with a service plan included consulting with DCBS staff before the development of a new case management care plan. One case was not applicable as the care plan did not require modification.	

Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
The DCBS and designated Contractor staff will sign each service plan to indicate their agreement with the plan. If the DCBS and Contractor staff cannot reach agreement on the service plan for a Member, information about that Member's physical health care needs, unresolved issues in developing the case management plan, and a summary of resolutions discussed by the DCBS and Contractor staff will be forwarded to the designated county DCBS worker. That DCBS staff member shall work with the designated Contractor representative and a designated Department representative, if needed, to agree on a service plan. If agreement is not reached through mediation, the service plan shall be referred to the Department for resolution through the appeals process.		~~Minimal~~ Substantial	Addressed in P/P CM-21 and document titled "Service Plans". <u>DCBS Service Plan File Review</u> None of the files with a service plan included signatures of both DCBS and the contractor. Service plans included the name of the DCBS staff person but not a signature. **<u>Recommendation for Humana CareSource</u>** Humana should continue to outreach to DCBS for service plans for all DCBS members and ensure signatures are completed, where possible.	Humana-CareSource does not believe that minimal compliance is an accurate determination. Humana CareSource continually outreaches to DCBS for signatures and will continue to do so. However, DCBS revised the service plan in 2014 and the 2013 Foster Care Form is no longer in use by DCBS. Humana-CareSource was asked by DCBS to use a new revised DCBS Foster Care Form. This form does not have a place for a signature of the DCBS MCO Liaison or the Humana-CareSource Foster Care Liaison. Humana-CareSource has ask the MCO liaison's to please have their workers sign this form at the bottom and then once received by our Foster Care Liaison, the Liaison will sign it and scan it into our documentation system. The new DCBS form that Humana-CareSource further impedes Humana-Care Source's ability to obtain signatures. <u>Final Review Determination:</u> Substantial Compliance The finding is based on the file review results. No Service Plans reviewed had a signature; however, Humana CareSource makes a significant effort to obtain the Service Plans and DCBS signatures. DMS has requested that Humana-CareSource

Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
				to clarify the issue of DCBS providing a new form. Please explain and provide a copy of the stated form. Per DMS's understanding, the current Service Plan form is Form 106-B.
35.5 Children Receiving Adoption Assistance				
Upon Enrollment with the Contractor, each Member receiving adoption assistance shall have a service plan prepared by DCBS. The process for enrollment of children receiving adoption assistance shall follow that outlined for Children in Foster Care.		~~Substantial~~ Full	Addressed in P/P CM-21 and document titled "Service Plans". DCBS Service Plan File Review 17 out of 20 cases included a service plan. **Recommendation for Humana CareSource** Humana CareSource should continue to outreach to DCBS for service plans for all DCBS members.	Humana-CareSource believes they are in full compliance with this contract requirement. Humana CareSource continually outreaches to DCBS for service plans for all DCBS members and will continue to do so. As per the contract, each child in Foster Care shall have a service plan prepared by DCBS. As Humana-CareSource must rely on the DCBS MCO Regional Liaisons and Case Workers to forward completed service plans to Humana-CareSource, the MCO can only encourage the receipt and work with DCBS to request those not received. As Humana-CareSource indicated during this audit, during 2013 Humana-CareSource had monthly meetings with DCBS Central Office Staff. In some cases, meetings were held on a weekly basis if there was an extremely challenging DCBS member and the need for collaborative efforts between Humana-CareSource, DCBS, CRP, BHDID, and DMS were identified. As indicated during the review, the Humana-

Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
				CareSource had also began having monthly meetings with the DCBS Regional Liaisons to facilitate the receipt of service plans from DCBS case workers, discuss any issues and to coordinate activities for the DCBS members. Humana-CareSource believes this meets the contract intent of monthly meetings, as in many cases there are multiple DCBS/MCO meetings in any given month. As service plans are a standing agenda item at the monthly meetings with DCBS, we believe we are actively pursuing the receipt of service plans and meeting this contract element fully. Final Review Determination: Full Compliance Humana-CareSource is correct that this requirement is met through the monthly meetings with DCBS Regional Liaisons that include Service Plans as a standing agenda item.
32. 9 Pediatric Sexual Abuse Examination				
Contractor shall have Providers in its network that have the capacity to perform a forensic pediatric sexual abuse examination. This examination must be conducted for Members at the request of the DCBS.		Minimal	Not addressed in documents provided. Contractor stated during interview that they do have providers in network that have the capacity to perform a forensic pediatric sexual abuse examination upon request. **Recommendation for Humana**	Prior to the on-site review, HUMANACARESOURCE provided a listing to the IPRO of in network providers who were qualified to do a forensic pediatric sexual abuse examination. This listing was titles "Pediatric Sexual Abuse Providers". The following listing was provided: Pediatric

Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			CareSource Humana CareSource should establish a policy/procedure that addresses this requirement.	Sexual Abuse Providers Melissa Currie, M.D., division chief Kelli Marvin, Ph.D. Lisa Pfitzer, M.D. Andrea Taroli, M.D. Gina Bertocci, Ph.D. Based on the documentation provided to the IPRO prior to the visit, Humana-CareSource believes this element should be in full compliance as it meets the contract requirement, which states "Contractor shall have Providers in its network that have the capacity to perform a forensic pediatric sexual abuse examination." There is no indication of a policy requirement related to this. Final Review Determination: No change in compliance level. IPRO checked all compliance documentation on its system, on the ftp site, and in hard copy and did not locate this list. Based on the recorded interview response, there is no change in the compliance level.
32.8 Pediatric Interface				
The Contractor shall establish procedures to coordinate care for children receiving school-based services and early intervention services, in a manner that prevents duplication of Contractor provided services. The Contractor shall monitor the continuity and coordination		Substantial	Policy/procedure addressing coordination of care for children receiving school-based services was not provided. The document "Coordination of PH BH and	HUMANACARESOURCE will develop a policy and procedure addressing coordination with schools and agencies that provide EI services and school-based services.

Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
of care for these children as part of its QAPI program. Services provided under these programs are authorized under the Federal Individuals with Disabilities Education Act, but typically excluded from Contractor coverage except in situations where a child's course of treatment is interrupted due to school breaks, after school hours or during summer months, the Contractor is responsible for providing all Medically Necessary Covered Services. IEP services should not be duplicated.			Early Intervention (EI) Services" states: "During 2013, the focus was on establishing contact and collaboration with many agencies including those offering early childhood intervention services. Regular meetings were held with the Department for Community Based Services (DCBS). Meetings were also held with the MCO DCBS liaisons for each service area. The Health Services Manager and Director met with the Commission for Children with Special Health Care Needs to answer questions and assess any needs. This was done in an effort to determine if there were needs existing that had not been met by traditional benefits or service availability. Our community education representatives have met with WIC, Head Start, and the Family Resource Youth Coordinators in the schools to provide plan education. A listing of visits with sites is contained in the community outreach tracking system. A Community Resource Share Point site was established that houses many community resources and agencies for referral such as WIC and Head Start. This site is routinely used by staff to provide additional resources to our members." During the interview, the Contractor also discussed at length procedures to coordinate care for children receiving school-based services and early intervention	

Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			services. **Recommendation for Humana CareSource** Humana CareSource should establish a policy/procedure addressing this requirement and document coordination with schools and agencies that provide EI services and school-based services.	
School-Based Services provided by schools are excluded from Contractor coverage and are paid by the Department through fee-for-service Medicaid when provided by a Medicaid enrolled provider. School-Based Services provided by public health departments are included in Contractor coverage. However, in situations where a child's course of treatment is interrupted due to school breaks, after school hours or during summer months, the Contractor is responsible for providing all Medically Necessary Covered Services. Coordination between the schools and the Contractor shall ensure that Members receive medically necessary services that complement the individual education plan (IEP) services and promote the highest level of function for the child.		Minimal	Policy/procedure addressing school-based services was not provided. During the interview, Contractor stated that during school breaks the Contractor is responsible for providing and coordinating all Medically Necessary Covered Services. **Recommendation for Humana CareSource** Humana CareSource should establish a policy/procedure addressing this requirement and document coordination with schools and agencies that provide EI services and school-based services.	Humana-CareSource will develop a policy and procedure addressing coordination with schools and agencies that provide EI services and school-based services.
The Contractor shall coordinate services between the First Steps program and Contractor coverage. The First Steps program is an entitlement program established by the Federal Individuals with Disabilities Education Act (IDEA) and is funded by federal, state and local funds. The goal of the program is to provide early intervention		Minimal	Policy/procedure addressing the First Steps program was not provided. The Provider Manual discusses the EPSDT program components for care of pediatric members from birth to 3 years of age	Humana-CareSource will develop a policy and procedure addressing coordination with the First Steps Program.

Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
services to children from birth up to age three who have developmental disabilities or delays. The intended outcome of the program is to ensure maximum amelioration of the impact of developmental disabilities or delays on infants and toddlers by early and ongoing provision of rehabilitation services.			including developmental assessment and history and provides for referral to specialists as needed for further evaluation. During onsite interview, the Contractor detailed that they frequently coordinate with the First Steps program. **Recommendation for Humana CareSource** Humana CareSource should establish a policy/procedure addressing this requirement and document coordination with the First Steps program.	
In order for Contractor and its Providers to effectively manage care for Members who qualify for these services, it will be necessary to coordinate the care provided through both programs as children who are receiving these services are identified, to share information with early intervention/school-based service providers with appropriate permission from parents.		Minimal	Policy/procedure addressing this requirement was not provided. During the interview, the Contractor described that care is coordinated and information is shared with appropriate permission from parents. **Recommendation for Humana CareSource** Humana CareSource should establish a policy/procedure addressing this requirement and document coordination with the First Steps program.	Humana-CareSource will develop a policy/procedure addressing coordinating the care provided through both programs and sharing information with early intervention/school-based service providers with appropriate permission from parents.
Services provided under HANDS shall be excluded from Contractor coverage. HANDS is a home visitation				

Case Management/Care Coordination (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: 438.208)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
program for first-time parents. It services children under three (3) years of age and it promotes good parenting skills.				
37.11 DCBS and DAIL Service Plans Reporting				
Thirty (30) days after the end of each quarter, the Contractor shall submit a quarterly report detailing the number of service plan reviews conducted for Guardianship, Foster and Adoption assistance Members outcome decisions, such as referral to case management, and rationale for decisions.		Full	Reports provided for DCBS\DAIL Members included: MCO Report #65 Foster Care provides a monthly snapshot of new/existing members, new/existing members enrolled in case management, new/existing members enrolled in disease management and new/existing members with Health Risk Assessments (HRAs) completed. MCO Report #66 Guardianship provides a monthly snapshot of new/existing guardian members, new/existing members enrolled in case management, new/existing members enrolled in disease management and new/existing members with HRAs completed. During onsite interview, contractor presented master schedule of outgoing reports and discussed reporting process.	

Case Management/Care Coordination/Department for Community Based Services (DCBS) Clients

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	22	5	5	0
Total Points	66	10	5	0

Overall Compliance Determination:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Range	**3.0**	**2.0 – 2.99**	**1.0 – 1.99**	**0 – 0.99**
Points Average		**2.53**		

As part of the review IPRO assessed the MCO's implementation of any actions proposed by the MCO in response to last year's findings. It should be noted that deficiencies previously identified that continue to be deficient in the current review may adversely affect the scoring of a requirement.

Reviewer Decision:

Full Compliance	MCO has met or exceeded requirements
Substantial Compliance	MCO has met most requirements but may be deficient in a small number of areas
Minimal Compliance	MCO has met some requirements but has significant deficiencies requiring corrective action
Non- Compliance	MCO has not met the requirements
Not Applicable (NA)	Statement does not require a review decision; for reviewer information purposes

Shading of Review Determination Column Only=Not subject to review, e.g., header, DMS responsibility
Shading of Columns for Review Determination, Comments and Health Plan's and DMS's Responses and Plan of Action=Not subject to review for the current review year, e.g., standard deemed due to full compliance achieved during prior review

Final Report 9/12/2014

Case Management/Care Coordination
Suggested Evidence

Documents

Policies/Procedures for:

- Identification of members for care management services
- Care coordination
- Comprehensive Assessment including guidelines for referral to care management programs
- Care Plan including criteria for care plan development
- ISHCN including identification, screening and assessment
- DCBS and DAIL clients
- Coordination of care for children receiving school-based services and early intervention services
- Pediatric sexual abuse examination
- Measurement of utilization, access, complaint and grievance, and satisfaction data for DCBS population.

Case manager and care coordinator position descriptions
Evidence of dissemination of information to members, member representatives and providers relating to care management services
Evidence of monitoring effectiveness of case management
Evidence of tracking, analysis, reporting and interventions for indicators measuring utilization, access, complaints and grievances, and satisfaction with care and services for DCBS population
Evidence of dissemination of information and materials specific to the needs of the ISHCN member
Evidence of practice guidelines or other criteria considering the needs of ISHCN

Reports

Monthly/quarterly reports of service plan reviews conducted for DCBS and DAIL clients
Number of DCBS and DAIL clients enrolled in the MCO as of the last day of the review period (December 31, 2013)
Number of DCBS and DAIL clients enrolled in the MCO who are enrolled in case management/care coordination as of the last day of the review period (December 31, 2013)
Monthly reports of Foster Care cases

Final Report 9/12/2014

File Review

Care Coordination files for a random sample of cases selected by EQRO
Logs of DCBS/MCO and DAIL/MCO meetings to review members
DCBS and DAIL Service Plans for a sample of cases selected by EQRO
DCBS Case Management files/claims records

KY EQRO ANNUAL REVIEW
March 2014
Period of Review: January 1, 2013– December 31, 2013
MCO: Humana CareSource

Final Report 9/5/2014

Enrollee Rights and Protection: Enrollee Rights *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
22.6 Member Rights and Responsibilities			**General Recommendation for Humana CareSource:** Policies, procedures, reports and documents should be consistent with regard to branding/MCO name and specific to Kentucky Medicaid. The full MCO name, Humana CareSource, should be used consistently.	Humana-CareSource is in the process of reviewing policies, procedures, reports, and documents to ensure branding consistency with the "Humana-CareSource" name and logo. Additionally, we are reviewing all policies and procedures to ensure they are Kentucky Medicaid specific.
The Contractor shall have written policies and procedures that are designed to protect the rights of Members and enumerate the responsibilities of each Member. A written description of the rights and responsibilities of Members shall be included in the Member information materials provided to new Members.		Full	This requirement is found in Policies SO-22 and EN-30 and the Member Handbook.	
A copy of these policies and procedures shall be provided to all of the Contractor's Network Providers to whom Members may be referred. In addition, these policies and procedures shall be provided to any Out-of-Network Provider upon request from the Provider.		Full	This requirement is found in Policy SO-22.	
The Contractor's written policies and procedures that are designed to protect the rights of Members shall include, without limitation, the right to:				
A. Respect, dignity, privacy, confidentiality and nondiscrimination;		Full	This requirement is found in Policy SO-22.	
B. A reasonable opportunity to choose a PCP and to change to another Provider in a reasonable manner;		Full	This requirement is found in Policy SO-22.	
C. Consent for or refusal of treatment and active participation in decision choices;		Full	This requirement is found in Policy SO-22.	

Final Report 9/5/2014

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
D. Ask questions and receive complete information relating to the Member's medical condition and treatment options, including specialty care;		Full	This requirement is found in Policy SO-22.	
E. Voice Grievances and receive access to the Grievance process, receive assistance in filing an Appeal, and receive a state fair hearing from the Contractor and/or the Department;		Full	This requirement is found in Policy SO-22.	
F. Timely access to care that does not have any communication or physical access barriers;		Full	This requirement is found in Policy SO-22.	
G. Prepare Advance Medical Directives pursuant to KRS 311.621 to KRS 311.643;		Full	This requirement is found in Policy SO-22.	
H. Assistance with Medical Records in accordance with applicable federal and state laws;		Full	This requirement is found in Policy SO-22.	
I. Timely referral and access to medically indicated specialty care; and		Full	This requirement is found in Policy SO-22.	
J. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.		Full	This requirement is found in Policy SO-22.	
The Contractor shall also have policies addressing the responsibility of each Member to:				
A. Become informed about Member rights:		Full	This requirement is found in Policy SO-22.	
B. Abide by the Contractor's and Department's policies and procedures;		Full	This requirement is found in Policy SO-22.	
C. Become informed about service and treatment options;		Full	This requirement is found in Policy SO-22.	
D. Actively participate in personal health and care decisions, practice healthy life styles;		Full	This requirement is found in Policy SO-22.	

Final Report 9/5/2014

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
E. Report suspected Fraud and Abuse; and		Full	This requirement is found in Policy SO-22.	
F. Keep appointments or call to cancel.		Full	This requirement is found in Policy SO-22.	
22.2 Member Handbook				
The Contractor shall publish a Member Handbook and make the handbook available to Members upon enrollment, to be delivered to the Member within five (5) business days of Contractor's notification of Member's enrollment. Contractor is in compliance with this requirement if the Member's handbook is mailed within five (5) business days by a method that will not take more than three (3) days to reach the Member.		Full	Policy EN-30 details the process in which KY Members are given the Member Handbook and New Member Kits and states that these are mailed on day 3 of notification of enrollment. The Plan stated during interview that an enrollee would then receive this kit in the mail including handbook within 5 business days of time plan was notified of enrollment.	
The Member Handbook shall be available in English, Spanish and any other language spoken by five (5) percent of the potential enrollee or enrollee population.		Substantial	The Policy CM-10 states "that marketing and member materials are available in any language that is the primary language that meets the percentage threshold set for the geographic service area by the state or CMS." **Recommendation for Humana** Policy should be revised to specify that the KY percentage threshold is 5%.	While the policy states that we will meet the plan specific requirements, Humana CareSource can add the threshold information to policy CM-10.
The Member Handbook shall be available in a hardcopy format as well as an electronic format online.		Full	This requirement is stated in Policy EN-30.	
The Contractor shall review the handbook at least annually and shall communicate any changes to Members in written form. Revision dates shall be added to the Member Handbook so that it is evident which version is the most current. Changes shall be approved by the Department prior to printing. The Department has		Substantial	Plan stated during interview they are currently in the process of approval of 2014 Member Handbook with state. Plan stated they do not currently have an annual revision policy for the Member	Language will be added to an existing policy or a new policy will be created that states the member handbook will be reviewed/revised (as necessary) on an annual basis. A version date or revision date, along with the KDMS approval date will be included on the Member Handbook.

Final Report 9/5/2014

Enrollee Rights and Protection: Enrollee Rights *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
the authority to review the Contractor's Member Handbook at any time.			Handbook, but stated that the Member Handbook is revised as needed. **Recommendation for Humana CareSource** A policy/procedure for updating the Member Handbook should be developed and include marking the Member Handbook with a version date or revision date and obtaining DMS approval.	
The handbook shall be written at the sixth grade reading comprehension level and shall include at a minimum the following information:		Full	Humana CareSource provided an e-mail indicating submission of the Member Handbook to KDMS and stating that the Flesch-Kincaid Grade is 6.9.	
A. The Contractor's Network of Primary Care Providers, including a list of the names, telephones numbers, and service site addresses of PCPs available for Primary Care Providers in the network listing. The network listing may be combined with the Member Handbook or distributed as a stand-alone document;		Full	The network list was found in Kentucky Directory 2013.	
B. The procedures for selecting a PCP and scheduling an initial health appointment;		Full	This requirement is found in the Member Handbook.	
C. The name of the Contractor and address and telephone number from which it conducts its business; the hours of business; and the Member Services telephone number and twenty-four/seven (24/7) toll-free medical call-in system;		Substantial	The Member Handbook contains the Contractor name, business telephone number, hours of business, the Member Services telephone number and the 24/7 toll-free medical call-in system. This requirement, with the exception of the Contractor's address, is found in the Member Handbook. **Recommendation for Humana CareSource**	The current version of the KY statewide member handbook (KY-MMED-532) includes our office address (page 3), whereas the version used for the IPRO audit did not.

Final Report 9/5/2014

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			The MCO should include the address from which business is conducted in Member Handbook.	
D. A list of all available Covered Services, an explanation of any service limitations or exclusions from coverage and a notice stating that the Contractor will be liable only for those services authorized by the Contractor;		Full	This requirement is found in the Member Handbook.	
E. Member rights and responsibilities including reporting suspected fraud and abuse;		Full	This requirement is found in the Member Handbook.	
F. Procedures for obtaining Emergency Care and non-emergency after hours care. For a life-threatening situation, instructs Members to use the emergency medical services available or to activate emergency medical services by dialing 911;		Full	This requirement is found in the Member Handbook.	
G. Procedures for obtaining transportation for both emergency and non-emergency situations;		Full	This requirement is found in the Member Handbook.	
H. Information on the availability of maternity, family planning and sexually transmitted disease services and methods of accessing those services;		Full	This requirement is found in the Section "Services that Do Need Prior Authorization" in the Member Handbook.	
I. Procedures for arranging EPSDT for persons under the age of 21 years;		Full	Procedures for arranging EPSDT services are stated in the Member Handbook.	
J. Procedures for obtaining access to Long Term Care Services;		Full	This requirement is found in the Member Handbook.	
K. Procedures for notifying the Department for Community Based Services (DCBS) of family size changes, births, address changes, death notifications;		Minimal	Procedures for notifying the Department for Community Based Services (DCBS) are not found in the Member Handbook. DCBS is mentioned on page 5 – regarding the Kentucky Health Choices ID card and on page 29, regarding eligibility/loss of	The current version of the KY statewide member handbook (KY-MMED-532) includes our office address (see page 3), whereas the version used for the IPRO audit did not. Page 4 of the current KY statewide member handbook (KY-MMED-532) includes information for

Final Report 9/5/2014

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			eligibility. Regarding family size changes, births are mentioned on page 5, but it states that the member should notify Humana CareSource to obtain and ID card for the baby. Address changes and death notifications were not found. **Recommendation for Humana CareSource** The Member Handbook should include information for members regarding contacting DCBS in the event of a birth, death or address change.	members regarding contacting DCBS in the event of a birth, death or address change. Also, DCBS contact information is included on the inside back cover as well as KDMS and other important state-related contact information.
L. A list of direct access services that may be accessed without the authorization of a PCP;		Full	This requirement is found in the Member handbook.	
M. Information about procedures for selecting a PCP or requesting a change of PCP and specialists; reasons for which a request may be denied; reasons a Provider may request a change;		Full	This requirement is found in the Member Handbook.	
N. Information about how to access care before a PCP is assigned or chosen;		Full	Policy SO-04 indicates that a member can contact Member Services to access care before a PCP is assigned or chosen.	
O. A Member's right to obtain second opinion and information on obtaining second opinions related to surgical procedures, complex and/or chronic conditions;		Full	This requirement is found in the Member Handbook.	
P. Procedures for obtaining Covered Services from non-network providers;		Full	This requirement is found in the Member Handbook.	
Q. Procedures for filing a Grievance or Appeal. This shall		Full	This requirement is found in the Member	

Final Report 9/5/2014

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
include the title, address, and telephone number of the person responsible for processing and resolving Grievances and Appeals;			Handbook.	
R. Information about the Cabinet for Health and Family Services' independent ombudsman program for Members;		Full	This requirement is found in the Member Handbook.	
S. Information on the availability of, and procedures for obtaining behavioral health/substance abuse health services;		Full	This requirement is found in the Member Handbook.	
T. Information on the availability of health education services;		Full	This requirement is found in the Member Handbook.	
U. Information deemed mandatory by the Department; and		Full	This requirement is found in the Member Handbook.	
V. The availability of care coordination, case management and disease management provided by the Contractor.		Full	This requirement is found in the Member Handbook.	
30.3 Second Opinions				
The Contractor shall provide for a second opinion related to surgical procedures and diagnosis and treatment of complex and/or chronic conditions within the Contractor's network, at the Member's request. The Contractor shall inform the Member, in writing, at the time of Enrollment, of the Member's right to request for a second opinion.		Full	Member notification is found in the Member Handbook. The right to a second opinion is also detailed in policy document titled "Second Opinions."	
22.1 Required Functions				
The Contractor shall have a Member Services function that includes a call center which is staffed and available by telephone Monday through Friday 7 am to 7 pm		Full	The required functions are found in Policy No. SO-04 and Report 11 Call Center.	

Final Report 9/5/2014

Enrollee Rights and Protection: Enrollee Rights *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Eastern Standard Time (EST). The call center shall meet the current American Accreditation Health Care Commission/URAC-designed Health Call Center Standard (HCC) for call center abandonment rate, blockage rate and average speed of answer. If a Contractor has separate telephone lines for different Medicaid populations, the Contractor shall report performance for each individual line separately. The Department will inform the Contractor of any changes/updates to these URAC call center standards.				
The Contractor shall also provide access to medical advice and direction through a centralized toll-free call-in system, available twenty-four (24) hours a day, seven (7) days a week nationwide. The twenty-four/seven (24/7) call-in system shall be staffed by appropriately trained medical personnel. For the purposes of meeting this requirement, trained medical professionals are defined as physicians, physician assistants, licensed practical nurses (LPN), and registered nurses (RNs).		Full	This requirement is found in Policy TR-13.	
The Contractor shall self-report their prior month performance in the three areas listed above, call center abandonment rate, blockage rate and average speed of answer, for their member services and twenty-four/seven (24/7) hour toll-free medical call-in system to the Department.		Full	2013 call center rates are detailed in the Report 11 Call Center document.	
Appropriate foreign language interpreters shall be provided by the Contractor and available free of charge and as necessary to ensure availability of effective communication regarding treatment, medical history, or health education. Member materials shall be provided and printed in each language spoken by five (5) percent or more of the Members in each county. The Contractor		Full	These requirements are found in Policy SO-04.	

Final Report 9/5/2014

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
staff shall be able to respond to the special communication need of the disabled, blind, deaf and aged and effectively interpersonally relate with economically and ethnically diverse populations. The Contractor shall provide ongoing training to its staff and Providers on matters related to meeting the needs of economically disadvantaged and culturally diverse individuals.				
The Contractor shall require that all Service Locations meet the requirements of the Americans with Disabilities Act, Commonwealth and local requirements pertaining to adequate space, supplies, sanitation, and fire and safety procedures applicable to health care facilities. The Contractor shall cooperate with the Cabinet for Health and Family Services' independent ombudsman program, including providing immediate access to a Member's records when written Member consent is provided.		Full	These requirements are found in Policy SO-04.	
The Contractor's Member Services function shall also be responsible for:				
A. Ensuring that Members are informed of their rights and responsibilities;		Full	These requirements are found in Policy SO-04.	
B. Monitoring the selection and assignment process of PCPs;		Full	These requirements are found in Policy SO-04.	
C. Identifying, investigating, and resolving Member Grievances about health care services;		Full	These requirements are found in Policy SO-04.	
D. Assisting Members with filing formal Appeals regarding plan determinations;		Full	These requirements are found in Policy SO-04.	
E. Providing each Member with an identification card that identifies the Member as a participant with the Contractor, unless otherwise approved by the		Full	These requirements are found in Policy SO-04.	

Final Report 9/5/2014

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Department;				
F. Explaining rights and responsibilities to members or to those who are unclear about their rights or responsibilities including reporting of suspected fraud and abuse;		Full	These requirements are found in Policy SO-04.	
G. Explaining Contractor's rights and responsibilities, including the responsibility to assure minimal waiting periods for scheduled member office visits and telephone requests, and avoiding undue pressure to select specific Providers or services;		Full	These requirements are found in Policy SO-04.	
H. Providing within five (5) business days of the Contractor being notified of the enrollment of a new Member, by a method that will not take more than three (3) days to reach the Member, and whenever requested by member, guardian or authorized representative, a Member Handbook and information on how to access services; (alternate notification methods shall be available for persons who have reading difficulties or visual impairments);		Full	Policy EN-30 details the process by which Members are provided the Member Handbook and Welcome Kit, and states that these are mailed on Day 3 of notification of enrollment. The Plan stated during interview that an enrollee would then receive the Welcome Kit/Member Handbook in the mail within 5 business days of time plan was notified of enrollment.	
I. Explaining or answering any questions regarding the Member Handbook;		Full	This requirement is found in Policy SO-04.	
J. Facilitating the selection of or explaining the process to select or change Primary Care Providers through telephone or face-to-face contact where appropriate. The Contractor shall assist members to make the most appropriate Primary Care Provider selection based on previous or current Primary Care Provider relationship, providers of other family members, medical history, language needs, provider location and other factors that		Full	The requirements are addressed by policies SO-04 and NO-30.	

Final Report 9/5/2014

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
are important to the Member. The Contractor shall notify members within thirty (30) days prior to the effective date of voluntary termination (or if Provider notifies Contractor less than thirty (30) days prior to the effective date, as soon as Contractor receives notice), and within fifteen (15) days prior to the effective date of involuntary termination if their Primary Care Provider leaves the Program and assist members in selecting a new Primary Care Provider;				
K. Facilitating direct access to specialty physicians in the circumstances of: (1) Members with long-term, complex health conditions; (2) Aged, blind, deaf, or disabled persons; and (3) Members who have been identified as having special healthcare needs and who require a course of treatment or regular healthcare monitoring. This access can be achieved through referrals from the Primary Care Provider or by the specialty physician being permitted to serve as the Primary Care Provider.		Full	This requirement is found in Policy SO-04.	
L. Arranging for and assisting with scheduling EPSDT Services in conformance with federal law governing EPSDT for persons under the age of twenty-one (21) years;		Full	This requirement is found in Policy SO-04.	
M. Providing Members with information or referring to support services offered outside the Contractor's Network such as WIC, child nutrition, elderly and child abuse, parenting skills, stress control, exercise, smoking cessation, weight loss, behavioral health and substance abuse;		Full	This requirement is found in Policy SO-04.	
N. Facilitating direct access to primary care vision services; primary dental and oral surgery services, and		Full	This requirement is found in Policy SO-04.	

Final Report 9/5/2014

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
evaluations by orthodontists and prosthodontists; women's health specialists; voluntary family planning; maternity care for Members under age 18; childhood immunizations; sexually transmitted disease screening, evaluation and treatment; tuberculosis screening, evaluation and treatment; and testing for HIV, HIV-related conditions and other communicable diseases; all as further described in Appendix I of this Contract;				
O. Facilitating access to behavioral health services and pharmaceutical services;		Full	This requirement is found in Policy SO-04.	
P. Facilitating access to the services of public health departments, Community Mental Health Centers, rural health clinics, Federally Qualified Health Centers, the Commission for Children with Special Health Care Needs and charitable care providers, such as Shriner's Hospital for Children;		Full	This requirement is found in Policy SO-04.	
Q. Assisting members in making appointments with Providers and obtaining services. When the Contractor is unable to meet the accessibility standards for access to Primary Care Providers or referrals to specialty providers, the Member Services staff function shall document and refer such problems to the designated Member Services Director for resolution;		Full	This requirement is found in Policy SO-04.	
R. Assisting members in obtaining transportation for both emergency and appropriate non-emergency situations;		Full	This requirement is found in Policy SO-04.	
S. Handling, recording and tracking Member Grievances properly and timely and acting as an advocate to assure Members receive adequate representation when seeking an expedited Appeal;		Full	This requirement is found in Policy SO-04.	
T. Facilitating access to Member Health Education		Full	This requirement is found in Policy SO-04.	

Final Report 9/5/2014

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Programs;				
U. Assisting members in completing the Health Risk Assessment (HRA) as outlined in **Covered Services** upon any telephone contact; and referring Members to the appropriate areas to learn how to access the health education and prevention opportunities available to them including referral to case management or disease management; and		Full	This requirement is found in Policy SO-04.	
V. The Member Services staff shall be responsible for making an annual report to management about any changes needed in Member Services functions to improve either the quality of care provided or the method of delivery. A copy of the report shall be provided to the Department.		Full	This requirement is found in Policy SO-04.	
30.4 Billing Members for Covered Services				
The Contractor and its Providers and Subcontractors shall not bill a Member for Medically Necessary Covered Services with the exception of applicable co-pays or other cost sharing requirements provided under this contract. Any Provider who knowingly and willfully bills a Member for a Medicaid Covered Service shall be guilty of a felony and upon conviction shall be fined, imprisoned, or both, as defined in Section 1128B(d)(1) 42 U.S.C. 1320a-7b of the Social Security Act. This provision shall remain in effect even if the Contractor becomes insolvent.		Substantial	This requirement is found in Policy CM-02. The provision regarding a provider billing a member for a Medicaid Covered Service is addressed in the Provider Manual but does not specify the potential criminal charges . **Recommendation for Humana CareSource** The Provider Manual should specify the possible criminal charges if a member is billed for a Medicaid Covered Service.	Humana CareSource will add the information regarding possible criminal charges for billing a member for a Medicaid Covered Service, to the Provider Manual.
However, if a Member agrees in advance in writing to pay for a Non-Medicaid covered service, then the Contractor, the Contractor's Provider, or Contractor's Subcontractor may bill the Member. The standard release form signed by the Member at the time of services does not relieve the Contractor, Providers and Subcontractors from the		Full	This requirement is found in the Provider Manual.	

Final Report 9/5/2014

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
prohibition against billing a Medicaid Member in the absence of a knowing assumption of liability for a Non-Medicaid covered Service. The form or other type of acknowledgement relevant to the Medicaid Member liability must specifically state the services or procedures that are not covered by Medicaid.				
22.9 Choice of Providers				
Dual Eligible Members, Members who are presumptively eligible, disabled children, and foster care children are not required to have a PCP. All other Members in the MCO must choose or have the Contractor select a PCP for their medical home.		Full	This requirement is stated in the Member Handbook.	
The Contractor shall have two processes in place for Members to choose a PCP: (A) a process for Members who have SSI coverage but are not Dual Eligible Members, and (B) a process for other Members.		Full	This requirement is stated in the Member Handbook.	
23.4 PCP Changes				
The Contractor shall have written policies and procedures for allowing Members to select or be assigned to a new PCP when such change is mutually agreed to by the Contractor and Member, when a PCP is terminated from coverage, or when a PCP change is as part of the resolution to an Appeal.		Full	This requirement is found in the Standard Operating Procedure (SOP) "PCP Change Requests".	
The Contractor shall allow the Members to select another PCP within ten (10) days of the approved change or the Contractor shall assign a PCP to the Member if a selection is not made within the timeframe.		Full	Addressed by SOP "PCP Change Requests". Additionally, plan indicated during interview that a member can change PCPs at any time.	
A member shall have the right to change the PCP 90 days after the initial assignment and once a year regardless of reason, and at any time for any reason as approved by		Full	Addressed by SOP "PCP Change Requests". Additionally, plan indicated during interview that a member can change PCPs	

Final Report 9/5/2014

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
the Member's Contractor. The Member may also change the PCP if there has been a temporary loss of eligibility and this loss caused the Member to miss the annual opportunity, if Medicaid or Medicare imposes sanctions on the PCP, or if the Member and/or the PCP are no longer located in the Contractor's Region.			at any time.	
The Member shall also have the right to change the PCP at any time for cause. Good cause includes the Member was denied access to needed medical services; the Member received poor quality of care; and the Member does not have access to providers qualified to treat his or her health care needs. If the Contractor approves the Member's request, the assignment will occur no later than first day of the second month following the month of the request.		Full	Addressed by SOP "PCP Change Requests". Additionally, plan indicated during interview that a member can change PCPs at any time.	
PCPs shall have the right to request a Member's Disenrollment from his/her practice and be reassigned to a new PCP in the following circumstances: incompatibility of the PCP/patient relationship or inability to meet the medical needs of the Member.		Full	This requirement is found in the Provider Manual.	
PCPs shall not have the right to request a Member's Disenrollment from their practice for the following: a change in the Member's health status or need for treatment; a Member's utilization of medical services; a Member's diminished mental capacity; or, disruptive behavior that results from the Member's special health care needs unless the behavior impairs the ability of the PCP to furnish services to the Member or others. Transfer requests shall not be based on race, color, national origin, handicap, age or gender. The Contractor shall have authority to approve all transfers.		Full	Addressed by provider non-discrimination policy of Provider Manual.	

Final Report 9/5/2014

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
The initial Provider must serve until the new Provider begins serving the Member, barring ethical or legal issues. The Member has the right to Appeal such a transfer in the formal Appeals process. The Provider shall make the change for request in writing. Member may request PCP change in writing, face to face or via telephone.		Full	The Provider Manual states that "The dismissing PCP will provide 30 days of emergency coverage to the patient from the date of dismissal" and that the request must be made in writing. In the interview, the Plan described that a member can contact member services at any time to change PCPs, and that member services would assist the member in obtaining care.	
The Contractor shall provide written notice within fifteen (15) days to a member whose PCP has been voluntarily or involuntarily disenrolled or been terminated from participation in the Contractor's network.		Non-Compliance	The Member Handbook states that Members will be notified "within 45 days" by mail if a PCP has been disenrolled or terminated from participation. It does not state "within 15 days". **Recommendation for Humana CareSource** The Member Handbook should state that the MCO will provide written notice within fifteen (15) days to a member whose PCP has been voluntarily or involuntarily disenrolled or been terminated from participation in the network.	Humana CareSource will make the required change to the Member Handbook to correct the time frame for notifying members for involuntary termination to 15 days. The 2014 version of the handbook does state 30 days (voluntary termination).
30.5 Referral for Non-covered Contractor Services				
When it is necessary for a Member to receive a Medicaid service that is outside the scope of the contract, the Contractor shall refer the Member to a provider enrolled in the Medicaid fee-for-service program. The Contractor shall have written policies and procedures for the referral of Member for Non-Covered services that shall provide		Full	The Member Handbook states that the Contractor shall cover any out-of-network service that they cannot provide in network. In addition, during the interview process,	

Final Report 9/5/2014

Enrollee Rights and Protection: Enrollee Rights (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.100, 438.207, 438.208, 438.210, 438.102, 438.106, 438.108, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
for the transition to a qualified health care provider and, where necessary, assistance to Members in obtaining a new Primary Care Provider. The Contractor shall submit any desired changes to the established written referral policies and procedures to the Department for review and approval.			a sample report was presented that demonstrated a Customer Service Representative referring a member requesting non-covered contractor services to a provider enrolled in the Medicaid fee-for-service program.	

Final Report 9/5/2014

Enrollee Rights and Protection: Enrollee Rights

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	80	4	1	1
Total Points	240	8	1	0

Overall Compliance Determination:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Range	**3.0**	**2.0 – 2.99**	**1.0 – 1.99**	**0 – 0.99**
Points Average		**2.90**		

As part of the review IPRO assessed the MCO's implementation of any actions proposed by the MCO in response to last year's findings. It should be noted that deficiencies previously identified that continue to be deficient in the current review may adversely affect the scoring of a requirement.

Reviewer Decision:

Full Compliance	MCO has met or exceeded requirements
Substantial Compliance	MCO has met most requirements but may be deficient in a small number of areas
Minimal Compliance	MCO has met some requirements but has significant deficiencies requiring corrective action
Non- Compliance	MCO has not met the requirements
Not Applicable (NA)	Statement does not require a review decision; for reviewer information purposes

Shading of Review Determination Column Only=Not subject to review, e.g., header, DMS responsibility
Shading of Columns for Review Determination, Comments and Health Plan's and DMS's Responses and Plan of Action=Not subject to review for the current review year, e.g., standard deemed due to full compliance achieved during prior review

Final Report 9/5/2014

Enrollee Rights and Protection: Enrollee Rights
Suggested Evidence

Documents

Policies/Procedures for:

- Member rights and responsibilities
- Choice of providers
- PCP changes
- Referral for non-covered services provided by FFS Medicaid providers
- Second Opinions
- Required member services functions including, but not limited to, call center and medical call-in system
- Cost Sharing

Member Handbook including any separate inserts or materials
Sample Member newsletters and other informational materials
Sample Provider newsletters and other informational materials
Provider Manual or evidence demonstrating that policies/procedures related to member rights and responsibilities are communicated to providers
Sample of member notifications of voluntary and involuntary PCP termination
Evidence of provision of Member Handbook within five business days of notification of enrollment

Reports

Census information on common ethnicities and languages other than English spoken by 5% or more of the enrolled population in a county
Annual Member Services Report
Call center metrics
Medical call-in system metrics

KY EQRO ANNUAL REVIEW
March 2014
Period of Review: January 1, 2013 – December 31, 2013
MCO: Humana CareSource

Final Report 9/5/2014

Enrollee Rights and Protection: Member Education and Outreach *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.206, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
22.3 Member Education and Outreach			**General Recommendation for Humana CareSource:** Policies, procedures, reports and documents should be consistent with regard to branding/MCO name and specific to Kentucky Medicaid. The full MCO name, Humana CareSource, should be used consistently.	Humana-CareSource is in the process of reviewing policies, procedures, reports, and documents to ensure branding consistency with the "Humana-CareSource" name and logo. Additionally, we are reviewing all policies and procedures to ensure they are Kentucky Medicaid specific.
The Contractor shall develop, administer, implement, monitor and evaluate a Member and community education and outreach program that incorporates information on the benefits and services of the Contractor's Program to all Members. The Outreach Program shall encourage Members and community partners to use the information provided to best utilize services and benefits.		Full	This requirement is found in MCO Report #86 Annual Outreach Plan.	
Educational and outreach efforts shall be carried on throughout the Contractor's Region. Creative methods will be used to reach Members and community partners. These will include but not be limited to collaborations with schools, homeless centers, youth service centers, family resource centers, public health departments, school-based health clinics, chamber of commerce, faith-based organizations, and other appropriate sites.		Full	This requirement is found in MCO Report #86 Annual Outreach Plan.	

Final Report 9/5/2014

Enrollee Rights and Protection: Member Education and Outreach (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.206, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
The Contractor shall submit an annual outreach plan to the Department for review and approval. The plan shall include the frequency of activities, the staff person responsible for the activities and how the activities will be documented and evaluated for effectiveness and need for change.		Full	The aforementioned Annual Outreach Plan report states the frequency of activities. During the interview, plan noted that activities are evaluated for effectiveness primarily by the amount of members that attend the activities versus the cost of the activity.	
22.4 Outreach to Homeless Persons				
The Contractor shall assess the homeless population within the Contractor's Region and by implementing and maintaining a customized outreach plan for Homeless Persons population, including victims of domestic violence.		Full	The customized outreach plan for the Homeless Persons population was found in Homeless Outreach Plan 2013. During the interview process, the plan stated that victims of domestic violence are a priority in outreach, and that opportunities to outreach victims of domestic violence are constantly being evaluated.	
The plan shall include: (A) utilizing existing community resources such as shelters and clinics; and (B) Face-to-Face encounters.		Full	This requirement is found in Homeless Outreach Plan 2013.	
The Contractor will not provide a differentiation of services for Members who are homeless. Victims of domestic violence should be a target for outreach as they are frequently homeless. Assistance with transportation to access health care may be provided via bus tokens, taxi vouchers or other arrangements when applicable.		Full	Plan detailed outreach efforts for homeless members and members of domestic violence during interview process, and a list of these efforts was provided. In addition, the plan said it hopes to offer bus tokens to access health care this year.	
22.5 Member Information Materials				

Final Report 9/5/2014

Enrollee Rights and Protection: Member Education and Outreach (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.206, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
All written materials provided to Members, including marketing materials, new member information, and grievance and appeal information shall be geared toward persons who read at a sixth-grade level,		Full	This requirement is met for all the marketing materials submitted.	
be published in at least a 14-point font size, and		Full	This requirement is met for all the marketing materials submitted.	
shall comply with the Americans with Disabilities Act of 1990 (Public Law USC 101-336).		Full	This requirement is found in Policy CM-10.	
Font size requirements shall not apply to Member Identification Cards.		Full	This requirement is found in Policy EN-30.	
Braille and audiotapes shall be available for the partially blind and blind.		Full	This requirement is found in Policy CM-10.	
Provisions to review written materials for the illiterate shall be available.		Full	Policy CM-10 details alternate formats that written materials can be distributed in, such as via audio, upon request.	
Telecommunication devices for the deaf shall be available.		Full	This requirement is found in SOP Interpreter Services- Relay Call Assistance.	
Language translation shall be available if five (5) percent of the population in any county has a native language other than English.		Full	This requirement is found in Policy CM-10.	
Materials shall be updated as necessary to maintain accuracy, particularly with regard to the list of participating providers.		Full	This requirement is found in Policy CM-10.	
All written materials provided to Members, including forms used to notify Members of Contractor actions and		Full	This requirement is found in Policy EN-30.	

Final Report 9/5/2014

Enrollee Rights and Protection: Member Education and Outreach (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 438.206, 438.10)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
decisions, with the exception of written materials unique to individual Members, unless otherwise required by the Department shall be submitted to the Department for review and approval prior to publication and distribution to Members.				
28.12 Cultural Consideration and Competency				
The Contractor shall participate in the Department's effort to promote the delivery of services in a culturally competent manner to all Members, including those with limited English proficiency and diverse cultural and ethnic backgrounds. The Contractor shall address the special health care needs of its members needing culturally sensitive services. The Contractor shall incorporate in policies, administration and service practice the values of: recognizing the Member's beliefs; addressing cultural differences in a competent manner; fostering in staff and Providers attitudes and interpersonal communication styles which respect Member's cultural background.		Full	This requirement is found in several policies and documents such as the MCO Report #86 Annual Outreach Plan and Policy CM-10. Plan also has a cultural competency plan.	
The Contractor shall communicate such policies to Subcontractors.		Full	This requirement is found in the Provider Manual.	

Final Report 9/5/2014

Enrollee Rights and Protection: Member Education and Outreach

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	18	0	0	0
Total Points	54	0	0	0

Overall Compliance Determination:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Range	**3.0**	**2.0 – 2.99**	**1.0 – 1.99**	**0 – 0.99**
Points Average	**3.0**			

As part of the review IPRO assessed the MCO's implementation of any actions proposed by the MCO in response to last year's findings. It should be noted that deficiencies previously identified that continue to be deficient in the current review may adversely affect the scoring of a requirement.

Reviewer Decision:

Full Compliance	MCO has met or exceeded requirements
Substantial Compliance	MCO has met most requirements but may be deficient in a small number of areas
Minimal Compliance	MCO has met some requirements but has significant deficiencies requiring corrective action
Non- Compliance	MCO has not met the requirements
Not Applicable (NA)	Statement does not require a review decision; for reviewer information purposes

Shading of Review Determination Column Only=Not subject to review, e.g., header, DMS responsibility
Shading of Columns for Review Determination, Comments and Health Plan's and DMS's Responses and Plan of Action=Not subject to review for the current review year, e.g., standard deemed due to full compliance achieved during prior review

Final Report 9/5/2014

Enrollee Rights and Protection: Member Education and Outreach
Suggested Evidence

Documents

Member and Community Education Outreach Plan
Outreach plan for homeless persons
Member Handbook
Member informational materials
Policies/procedures for promoting delivery of services in a culturally competent manner and evidence of communicating these policies/procedures to subcontractors

Reports

Reports of outreach activities

KY EQRO ANNUAL REVIEW
March 2014
Period of Review: January 1, 2013 – December 31, 2013
MCO: Humana CareSource

Final Report 9/5/2014

Medical Records *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 417.436[d])	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
38.1 Medical Records			**General Recommendation for Humana CareSource:** Policies, procedures, reports and documents should be consistent with regard to branding/MCO name and specific to Kentucky Medicaid. The full MCO name, Humana CareSource, should be used consistently.	Humana-CareSource is in the process of reviewing policies, procedures, reports, and documents to ensure branding consistency with the "Humana-CareSource" name and logo. Additionally, we are reviewing all policies and procedures to ensure they are Kentucky Medicaid specific.
Member Medical Records if maintained by the Contractor shall be maintained timely, legible, current, detailed and organized to permit effective and confidential patient care and quality review. Complete Medical Records include, but are not limited to, medical charts, prescription files, hospital records, provider specialist reports, consultant and other health care professionals' findings, appointment records, and other documentation sufficient to disclose the quantity, quality, appropriateness, and timeliness of services provided under the Contract. The medical record shall be signed by the provider of service.		Full	This requirement is addressed in the Participation Agreements with Hospitals, Physicians and Independent Practice Associations and in the Provider Manual.	

KY EQRO ANNUAL REVIEW
March 2014
Period of Review: January 1, 2013 – December 31, 2013
MCO: Humana CareSource

Final Report 9/5/2014

Medical Records *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation 417.436[d])	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
The Contractor shall have medical record confidentiality policies and procedures in compliance with state and federal guidelines and HIPAA. The Contractor shall protect Member information from unauthorized disclosure as set forth in Confidentiality of Records of this Agreement.		Full	This requirement is addressed in the Participation Agreements with Hospitals, Physicians and Independent Practice Associations and the Provider Manual. The Manual includes examples of controls that providers may use.	.
The Contractor shall conduct HIPAA privacy and security audits of providers as prescribed by the Department.		Substantial	The Humana 2014 KY Market Addendum Corporate Quality Improvement Program Description (QIPD) Medicaid Managed Care Program states that the Privacy Officer is responsible for implementing and auditing of policies. A document addressing conduct of audits as prescribed by the Department was not available. During provider site visits, provider representatives confirm that the provider office has HIPAA policies in place. Per Humana CareSource, the MCO's audit process of provider medical records is currently in development. The focus for 2014 will be primary care. **<u>Recommendation for Humana CareSource</u>** A policy/procedure should address conduct of audits of privacy practices prescribed by the Department.	Humana-Care Source agrees with this recommendation. The Plan currently uses a site visit tool with a key that includes auditing the provider office and documentation of HIPAA compliance. A policy and procedure will be developed regarding the tools and activities.

Final Report 9/5/2014

Medical Records (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 417.436[d])	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
The Contractor shall include provisions in its Subcontracts for access to the Medical Records of its Members by the Contractor, the Department, the Office of the Inspector General and other authorized Commonwealth and federal agents thereof, for purposes of auditing. Additionally, Provider contracts shall provide that when a Member changes PCP, the Medical Records or copies of Medical Records shall be forwarded to the new PCP or Partnership within ten (10) Days from receipt of request. The Contractor's PCPs shall have Members sign a release of Medical Records before a Medical Record transfer occurs.		Full	This requirement is addressed in the Physician Participation Agreement. Page 26 indicates, ' Within ten (10) days from receipt of request, transfer the medical records of a Member to a new PCP when the Member changes PCPs.'	
The Contractor shall have a process to systematically review provider medical records to ensure compliance with the medical records standards. The Contractor shall institute improvement and actions when standards are not met. The Contractor shall have a mechanism to assess the effectiveness of practice-site follow-up plans to increase compliance with the Contractor's established medical records standards and goals.		Full	This requirement is addressed on page 28 of the Physician Participation Agreement.	
The Contractor shall develop methodologies for assessing performance/compliance to medical record standards of PCP's/PCP sites, high risk/high volume specialist, dental		Full	This requirement is addressed with a policy on random medical record review that is conducted annually. The plan provided policy QM-039-10 Primary Care Physician Selection and Process for Random Medical	

Final Report 9/5/2014

Medical Records (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 417.436[d])	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
providers, providers of ancillaries services not less than every three (3) years. Audit activity shall, at a minimum:			Record Documentation Review (MRDR). The policy/procedure describes the primary care physician medical record selection and medical record documentation review (MRDR) process performed annually by the Quality Operations Compliance and Accreditation (QOCA) department The MCO will begin medical record audits in 2014.	
A. Demonstrate the degree to which providers are complying with clinical and preventative care guidelines adopted by the Contractor;		Full	This requirement is addressed with the following documentation provided by the plan: the 2013 KY MRDR Medical Records Documentation Review summary report. The report indicates the Quality Nurses reviewed a sample of 104 medical records from 14 Kentucky and West Virginia primary care providers for Commercial HMO/NPOS, and PPO members, Medicare HMO, PPO and PFFS members, and Medicaid HMO members. The reviews were conducted to determine compliance with medical record documentation standards, continuity and coordination of care, and patient safety.	
B. Allow for the tracking and trending of individual and plan wide provider performance over time;		Full	The report noted above includes trending of results for 2012 and 2013. This report includes 2 state markets and several populations such that results specific to the KY Medicaid population are not evident. The report includes analysis of results and identification of areas for improvements.	

Final Report 9/5/2014

Medical Records (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 417.436[d])	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			The 3 targeted areas identified include: advance directives, immunization records and documentation of smoking/alcohol/substance abuse.	
C. Include mechanism and processes that allow for the identification, investigation and resolution of quality of care concerns; and		Full	Addressed in the QI Program Description.	
D. Include mechanism for detecting instances of over-utilization, under-utilization, and miss utilization.		Full	Addressed in the QI Program Description, QI Work Plan and UM Program Description. The UM Work Group analyzes utilization data and reports to the UM Committee. Overutilization measures include but are not limited to: 1) ER visits per 1000 members by PCP 2) Inpatient visits per 1000 members by PCP 3) Prescriptions PMPY 4) Cost per prescription 5) Utilization by provider compared to peer providers Underutilization measures include: 1) Encounters/1000 2) Readmission analysis as discussed above 3) HEDIS measures such as Well Child Rates etc.	
27.6 Medical Records				
The Contractor shall require their Providers to maintain Member medical		Full	Addressed in the Provider Manual.	

Final Report 9/5/2014

Medical Records (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 417.436[d])	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
records on paper or in an electronic format. Member Medical Records shall be maintained timely, legible, current, detailed and organized to permit effective and confidential patient care and quality review. Complete Medical Records include, but are not limited to, medical charts, prescription files, hospital records, provider specialist reports, consultant and other health care professionals' findings, appointment records, and other documentation sufficient to disclose the quantity, quality, appropriateness, and timeliness of services provided under the Contract. The medical record shall be signed by the provider of service.				
The Member's Medical Record is the property of the Provider who generates the record. However, each Member or their representative is entitled to one free copy of his/her medical record. Additional copies shall be made available to Members at cost. Medical records shall generally be preserved and maintained for a minimum of five (5) years unless federal requirements mandate a longer retention period (i.e. immunization and tuberculosis records are required to be kept for a person's lifetime).		Full	This requirement is addressed on page 23 of the document "KY AP Physician Agreement". The document indicates, the "Physician agrees to maintain such records, including electronic storage media, as are necessary to document the extent of services furnished to Members for a minimum of five (5) years or as otherwise required by state and federal laws, and for such additional time as may be necessary in the event of an audit, quality of care issue, or other dispute, and to furnish Humana and authorized state and federal agencies with any information requested regarding payments claimed for furnishing services under a Humana	

Final Report 9/5/2014

Medical Records (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 417.436[d])	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			Kentucky Medicaid product or plan."	
The Contractor shall ensure that the PCP maintains a primary medical record for each member, which contains sufficient medical information from all providers involved in the Member's care, to ensure continuity of care. The medical chart organization and documentation shall, at a minimum, require the following:		Full	This requirement is addressed in the Physician Agreement documents provided by the plan.	
A. Member/patient identification information, on each page;		Full	Addressed in the Provider Manual.	
B. Personal/biographical data, including date of birth, age, gender, marital status, race or ethnicity, mailing address, home and work addresses and telephone numbers, employer, school, name and telephone numbers (if no phone contact name and number) of emergency contacts, consent forms, identify language spoken and guardianship information;		Full	Addressed in the Provider Manual.	
C. Date of data entry and date of encounter;		Full	Addressed in the Provider Manual.	
D. Provider identification by name;		Full	Addressed in the Provider Manual.	
E. Allergies, adverse reactions and any known allergies shall be noted in a prominent location;		Full	Addressed in the Provider Manual.	
F. Past medical history, including serious		Full	Addressed in the Provider Manual.	

Final Report 9/5/2014

Medical Records (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 417.436[d])	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
accidents, operations, and illnesses. For children, past medical history includes prenatal care and birth information, operations, and childhood illnesses (i.e. documentation of chickenpox);				
G. Identification of current problems;		Full	Addressed in the Provider Manual.	
H. The consultation, laboratory, and radiology reports filed in the medical record shall contain the ordering provider's initials or other documentation indicating review;		Full	Addressed in the Provider Manual.	
I. Documentation of immunizations pursuant to 902 KAR 2:060;		Full	Addressed in the Provider Manual.	
J. Identification and history of nicotine, alcohol use or substance abuse;		Full	Addressed in the Provider Manual.	
K. Documentation of reportable diseases and conditions to the local health department serving the jurisdiction in which the patient resides or Department for Public Health pursuant to 902 KAR 2:020;		Full	Addressed in the Provider Manual.	
L. Follow-up visits provided secondary to reports of emergency room care;		Full	Addressed in the Provider Manual.	
M. Hospital discharge summaries;		Full	Addressed in the Provider Manual.	
N. Advanced Medical Directives, for adults;		Full	Addressed in the Provider Manual.	
O. All written denials of service and the		Full	Addressed in the Provider Manual.	

Final Report 9/5/2014

Medical Records (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 417.436[d])	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
reason for the denial; and				
P. Record legibility to at least a peer of the writer. Any record judged illegible by one reviewer shall be evaluated by another reviewer.		Full	Addressed in the Provider Manual.	
A Member's medical record shall include the following minimal detail for individual clinical encounters:				
A. History and physical examination for presenting complaints containing relevant psychological and social conditions affecting the patient's medical/behavioral health, including mental health, and substance abuse status;		Full	Addressed in the Provider Manual.	
B. Unresolved problems, referrals and results from diagnostic tests including results and/or status of preventive screening services (EPSDT) are addressed from previous visits; and		Full	Addressed in the Provider Manual.	
C. Plan of treatment including: 1. Medication history, medications prescribed, including the strength, amount, directions for use and refills; and 2. Therapies and other prescribed regimen; and 3. Follow-up plans including consultation and referrals and directions, including time to return.		Full	Addressed in the Provider Manual.	

Final Report 9/5/2014

Medical Records (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 417.436[d])	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
27.7 Advance Medical Directives				
The Contractor shall comply with laws relating to Advance Medical Directives pursuant to KRS 311.621 – 311.643 and 42 CFR Part 489, Subpart I and 42 CFR 422.128, 438.6 and 438.10 Advance Medical Directives, including living wills or durable powers of attorney for health care, allow adult Members to initiate directions about their future medical care in those circumstances where Members are unable to make their own health care decisions.		Full	The document "QM-222-03 Humana Medical Record Documentation Review Tool" includes criteria to check for advance directives. Addressed in P/PCM-05, Advance Health Care Directives.	
The Contractor shall, at a minimum, provide written information on Advance Medical Directives to all Members and shall notify all Members of any changes in the rules and regulations governing Advance Medical Directives within ninety (90) Days of the change and provide information to its PCPs via the Provider Manual and Member Services staff on informing Members about Advance Medical Directives.		Full	Addressed in the Member Handbook and Provider Manual. Addressed in P/PCM-05, Advance Health Care Directives	
PCPs have the responsibility to discuss Advance Medical Directives with adult Members at the first medical appointment and chart that discussion in the medical record of the Member.		Full	Addressed in the Provider Manual.	
38.2 Confidentiality of Records				

Final Report 9/5/2014

Medical Records (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 417.436[d])	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
The parties agree that all information, records, and data collected in connection with this Contract, including Medical Records, shall be protected from unauthorized disclosure as provided in 42 CFR Section 431, subpart F, KRS 194.060A, KRS 214.185, KRS 434.840 to 434.860, and any applicable state and federal laws, including the laws specified in Section 40.12.		Full	The Humana CareSource executed agreement with the Department addresses confidentiality/HIPAA as well as the final Humana CareSource Appendix O Business Associate Agreement. Humana CareSource provided Privacy Policy-Confidentiality of Individual Information, dated 3/2013 that also addresses this requirement.	
The Contractor shall have written policies and procedures for maintaining the confidentiality of Member information consistent with applicable laws. Policies and procedures shall include, but not be limited to, adequate provisions for assuring confidentiality of services for minors who consent to diagnosis and treatment for sexually transmitted disease, alcohol and other drug abuse or addiction, contraception, or pregnancy or childbirth without parental notification or consent as specified in KRS 214.185. The policies and procedures shall also address such issues as how to contact the minor Member for any needed follow-up and limitations on telephone or mail contact to the home.		Full	Addressed by Humana CareSource Privacy Policy-Confidentiality of Individual Information.	
The Contractor on behalf of its employees, agents and assigns, shall sign a confidentiality agreement.		Full	Addressed by the Humana CareSource executed agreement with the Department and the final Humana CareSource Appendix O Business Associate Agreement.	

Final Report 9/5/2014

Medical Records (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation 417.436[d])	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
Except as otherwise required by law, regulations or this contract, access to such information shall be limited by the Contractor and the Department to persons who or agencies which require the information in order to perform their duties related to the administration of the Department, including, but not limited to, the US Department of Health and Human Services, U.S. Attorney's Office, the Office of the Inspector General, the Office of the Attorney General, and such others as may be required by the Department.		Full	Addressed by Humana CareSource Privacy Policy-Confidentiality of Individual Information.	
40.12 Health Insurance Portability and Accountability Act				
The Contractor agrees to abide by the rules and regulations regarding the confidentiality of protected health information as defined and mandated by the Health Insurance Portability and Accountability Act (42 USC 1320d) and set forth in federal regulations at 45 CFR Parts 160 and 164. Any Subcontract entered by the Contractor as a result of this agreement shall mandate that the subcontractor be required to abide by the same statutes and regulations regarding confidentiality of protected health information as is the Contractor.		Full	The Humana CareSource executed agreement with the Department addresses confidentiality/HIPAA as well as the final Humana CareSource Appendix O Business Associate Agreement. Humana CareSource provided Privacy Policy-Confidentiality of Individual Information, dated 3/2013 that also addresses this requirement. Addressed in subcontractor agreements.	

IPRO
Improving Healthcare for the Common Good

KY EQRO ANNUAL REVIEW
March 2014
Period of Review: January 1, 2013 – December 31, 2013
MCO: Humana CareSource

Final Report 9/5/2014

Medical Records

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	39	1	0	0
Total Points	117	2	0	0

Overall Compliance Determination:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Range	**3.0**	**2.0 – 2.99**	**1.0 – 1.99**	**0 – 0.99**
Points Average		**2.98**		

As part of the review IPRO assessed the MCO's implementation of any actions proposed by the MCO in response to last year's findings. It should be noted that deficiencies previously identified that continue to be deficient in the current review may adversely affect the scoring of a requirement.

Reviewer Decision:

Full Compliance	MCO has met or exceeded requirements
Substantial Compliance	MCO has met most requirements but may be deficient in a small number of areas
Minimal Compliance	MCO has met some requirements but has significant deficiencies requiring corrective action
Non- Compliance	MCO has not met the requirements
Not Applicable (NA)	Statement does not require a review decision; for reviewer information purposes

Shading of Review Determination Column Only=Not subject to review, e.g., header, DMS responsibility
Shading of Columns for Review Determination, Comments and Health Plan's and DMS's Responses and Plan of Action=Not subject to review for the current review year, e.g., standard deemed due to full compliance achieved during prior review

Final Report 9/5/2014

Medical Records
Suggested Evidence

Documents

Policies/procedures for:

- Confidentiality/HIPAA
- Access to medical records
- Transfer of records
- Medical records and documentation standards
- Process and tools for assessing/monitoring provider compliance with medical record standards including performance goals
- Advance Medical Directives

Sample contracts between MCO and network providers and subcontractors demonstrating provisions for medical records and documentation standards; and confidentiality/HIPAA requirements
Member materials related to Advance Directives
Provider materials related to Advance Directives
Evidence of signed confidentiality agreement on behalf of employees, agents and assigns

Reports

Provider compliance assessment/monitoring results and follow-up

KY EQRO ANNUAL REVIEW
March 2014
Period of Review: January 1, 2013 – December 31, 2013
MCO: Humana CareSource

Final Report 9/5/2014

Behavioral Health Services *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
33.3 General Behavioral Health Requirements			**General Recommendation for Humana CareSource:** Policies, procedures, reports and documents should be consistent with regard to branding/MCO name and specific to Kentucky Medicaid. The full MCO name, Humana CareSource, should be used consistently.	Humana-CareSource is in the process of reviewing policies, procedures, reports, and documents to ensure branding consistency with the "Humana-CareSource" name and logo. Additionally, we are reviewing all policies and procedures to ensure they are Kentucky Medicaid specific.
The Department requires the Contractor's provision of mental health services to be recovery and resiliency focused. This means that services will be provided to allow individuals, or in the case of, a minor, family or guardian, to have the greatest opportunities for decision making and participation in the individual's treatment and rehabilitation plans.		Full	Addressed in Beacon Health Strategies (BHS)/Humana CareSource Provider Manual.	
33.4 Covered Behavioral Health Services				
The Contractor shall assure the provision of all Medically Necessary Behavioral Health Services for Members. These services are described in Appendix I.		Full	Addressed in Beacon Health Strategies (BHS)/Humana CareSource Provider Manual. Addressed in Beacon Health Strategies Contract and BHS P/P QM 24.19 Availability and Accessibility of Clinical Services Addressed in ChoiceCare Network Provider Agreement, Humana Network Provider Agreement and Beacon Health Strategies Provider Services Agreement.	

Final Report 9/5/2014

Behavioral Health Services *(See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
All Behavioral Health services shall be provided in conformance with the access standards established by the Department. When assessing Members for BH Services, the Contractor and its providers shall use the DSM-IV multi-axial classification. The Contractor may require use of other diagnostic and assessment instrument/outcome measures in addition to the DSM-IV.		Full	Addressed in Beacon Health Strategies (BHS)/Humana CareSource Provider Manual. Addressed in Beacon Health Strategies Contract and BHS P/P QM 24.19 Availability and Accessibility of Clinical Services Addressed in ChoiceCare Network Provider Agreement, Humana Network Provider Agreement and Beacon Health Strategies Provider Services Agreement.	
Providers shall document DSM-IV diagnosis and assessment/outcome information in the Member's medical record.		Full	Addressed in Beacon Health Strategies (BHS)/Humana CareSource Provider Manual.	
33.5 Behavioral Health Provider Network				
The Contractor must emphasize utilization management, assuring the services authorized are provided, are medically necessary and produce positive health outcomes. The Department and DBHDID will coordinate on the requirement of data collection and reporting to assure that state and federal funds utilized in financing behavioral health services are efficiently utilized and meet the overall goals of health outcomes.		Full	Addressed in Beacon Health Strategies (BHS)/Humana CareSource Provider Manual. Addressed in Beacon Health Strategies Provider Services Agreement and BHS Utilization Management (UM) Program Description.	

Final Report 9/5/2014

Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
The Contractor shall utilize DSM-IV classification for Behavioral Health billings.		Full	Addressed in Beacon Health Strategies (BHS)/Humana CareSource Provider Manual.	
The Contractor shall provide access to psychiatrists, psychologists, and other behavioral health service providers.		Full	Addressed in Beacon Health Strategies Contract and BHS P/P QM 24.19 Availability and Accessibility of Clinical Services	
In order to meet the provider network requirement for BH services, Community Mental Health Centers (CMHCs) located within the Contractor service region shall be offered participation in the Contractor provider network.		Full	Humana CareSource offered participation to CMHCs and has CMHCs in network. Addressed in Kentucky Medicaid Humana CareSource GeoAccess Report 2013 and BHS Humana CareSource Provider Locations Map.	
Network providers shall have experience serving children and adolescents, persons with disabilities, the elderly, and cultural or linguistic minorities.		Full	Addressed by Humana CareSource P/P NO-28.	
The Contractor shall ensure accessibility and availability of qualified providers to all Members in the service area pursuant to Provider Program Capacity Demonstration as contained in the RFP. When necessary to meet the access standards for Behavioral Health Services for its Members, the Contractor may include in its provider network other specialty care clinic providers with comparable core services of the CMHC's.		Full	Addressed in Kentucky Medicaid Humana CareSource GeoAccess Report 2013 and BHS Humana CareSource Provider Locations Map. Addressed in CareSource and Beacon Health Strategies Contract.	
To the extent that non-psychiatrists and other providers		Full	Addressed in Kentucky Medicaid	

Final Report 9/5/2014

Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
of Behavioral health services may also be provided as a component of FQHC and RHC services, these facilities shall be offered the opportunity to participate in the Behavioral Health network. FQHC and RHC providers can continue to provide the same services they currently provide under their licenses.			Humana CareSource GeoAccess Report 2013 and BHS Humana CareSource Provider Locations Map.	
Since the Contractors shall offer participation agreements to the Community Mental Health Centers to participate in their Behavioral Health network, should a Community Mental Health Center decline participation in the Contractor in that service area, or if the Contractor fails to meet access or any other terms and conditions of the contract the Contractor may meet its BH network requirements by offering participation to other qualified specialty care clinic providers with comparable core CMHC services.		Full	Addressed in Kentucky Medicaid Humana CareSource GeoAccess Report 2013 and BHS Humana CareSource Provider Locations Map.	
The Contractor shall maintain a Member education process to help Members know where and how to obtain Behavioral Health Services.		Full	Contractor provided Humana CareSource New Member Kits during the interview, and also provided member education materials from the contractor's website.	
The Contractor shall permit Members to participate in the selection of the appropriate behavioral health individual practitioner(s) who will serve them and shall provide the Member with information on accessible in-network Providers with relevant experience.		Full	Addressed by BHS P/P UM 62.27 Member Services and Clinical Referral and Triage Process.	
33.6 Behavioral Health Services Hotline				
The Contractor shall have an emergency and crisis Behavioral Health Services Hotline staffed by trained		Full	Addressed by BHS P/P UM 289.02 Emergency Care and 24 Hour Access to	

Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
personnel twenty-four (24) hours a day, seven (7) days a week, three hundred sixty-five (365) days a year, toll-free throughout the Contractor's region.			Utilization Review Staff, BHS P/P UM 62.27 Member Services and Clinical Referral and Triage Process and BHS P/P QM 24.19 Availability and Accessibility of Clinical Services and BHS P/P 87.16 Response to Emergency Situations.	
Crisis hotline staff must include or have access to qualified Behavioral Health Services professionals to assess, triage and address specific behavioral health emergencies.		Full	Addressed by BHS P/P UM 289.02 Emergency Care and 24 Hour Access to Utilization Review Staff, BHS P/P UM 62.27 Member Services and Clinical Referral and Triage Process and BHS P/P QM 24.19 Availability and Accessibility of Clinical Services and BHS P/P 87.16 Response to Emergency Situations.	
Emergency and crisis Behavioral Health Services may be arranged through mobile crisis teams. Face to face emergency services shall be available twenty-four (24) hours a day, seven (7) days a week.		Full	Addressed by BHS P/P UM 289.02 Emergency Care and 24 Hour Access to Utilization Review Staff, BHS P/P UM 62.27 Member Services and Clinical Referral and Triage Process and BHS P/P QM 24.19 Availability and Accessibility of Clinical Services and BHS P/P UM 87.16 Response to Emergency Situations.	
It is not acceptable for an intake line to be answered by an answering machine.		Full	Addressed by BHS P/P UM 289.02 Emergency Care and 24 Hour Access to Utilization Review Staff.	
The Contractor shall ensure that the toll-free Behavioral Health Services Hotline meets the following minimum performance requirements for all Contractor Programs and Service Areas:		Substantial	Contractor submitted Hotline data for the months of February 2013 through December of 2013. The Hotline met or exceeded all of the minimum	Humana CareSource and BHS understand the importance of ensuring that the toll-free BH hotline meets minimum performance requirements. Humana

Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			performance requirements for most months of the year with the exception of July 2013 – where one performance requirement was not met. January 2013 Call Center report submitted by the contractor during the interview was missing the page detailing the Behavioral Health Hotline statistics, thus January 2013 data cannot be evaluated. **Recommendation to Humana CareSource/BHS** Humana CareSource/BHS should ensure that the toll-free Behavioral Health Services Hotline meets the minimum performance requirements for all Contractor Programs and Service Areas.	CareSource monitors the hotline performance through monthly reporting (Report 11) which is discussed at monthly joint Compliance calls. If any Compliance concerns are recognized the process is reviewed. If any issues of non-compliance arise Humana CareSource creates an internal Corrective Action Plan (CAP).
A. Ninety-nine percent (99%) of calls are answered by the fourth ring or an automated call pick-up system;		Substantial	100% of the calls were answered by the fourth ring for all months of the year evaluated. January 2013 Call Center report submitted by the contractor during the interview was missing the page detailing the Behavioral Health Hotline statistics, thus January 2013 data cannot be evaluated. **Recommendation to Humana**	Humana CareSource and BHS understand the importance of ensuring that the toll-free BH hotline meets minimum performance requirements. Humana CareSource monitors the hotline performance through monthly reporting (Report 11) which is discussed at monthly joint Compliance calls. If any Compliance concerns are recognized the process is reviewed. If any issues of non-compliance arise Humana CareSource creates an internal Corrective Action Plan (CAP).

Final Report 9/5/2014

Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			CareSource/BHS Humana CareSource/BHS should ensure that the toll-free Behavioral Health Services Hotline meets the minimum performance requirements for all Contractor Programs and Service Areas.	
B. No incoming calls receive a busy signal;		Full	Addressed by BHS P/P UM 87.16 Response to Emergency Situations.	
C. At least eighty percent (80%) of calls must be answered by toll-free line staff within thirty (30) seconds measured from the time the call is placed in queue after selecting an option;		Substantial	100% of calls were answered within 30 seconds for most months of 2013, but in July 2013 only 75% were answered within 30 seconds. January 2013 Call Center report submitted by the contractor during the interview was missing the page detailing the Behavioral Health Hotline statistics, thus January 2013 data cannot be evaluated. **Recommendation to Humana CareSource/BHS** Humana CareSource/BHS should ensure that the toll-free Behavioral Health Services Hotline meets the minimum performance requirements for all Contractor Programs and Service Areas.	Humana CareSource and BHS understand the importance of ensuring that the toll-free BH hotline meets minimum performance requirements. Humana CareSource monitors the hotline performance through monthly reporting (Report 11) which is discussed at monthly joint Compliance calls. If any Compliance concerns are recognized the process is reviewed. If any issues of non-compliance arise Humana CareSource creates an internal Corrective Action Plan (CAP).
D. The call abandonment rate is seven percent (7%) or less;		Substantial	Call abandonment rate was 0% for all months evaluated.	Humana CareSource and BHS understand the importance of ensuring that the toll-free BH hotline meets minimum

Final Report 9/5/2014

Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			January 2013 Call Center report submitted by the contractor during the interview was missing the page detailing the Behavioral Health Hotline statistics, thus January 2013 data cannot be evaluated. **Recommendation to Humana CareSource/BHS** Humana CareSource/BHS should ensure that the toll-free Behavioral Health Services Hotline meets the minimum performance requirements for all Contractor Programs and Service Areas.	performance requirements. Humana CareSource monitors the hotline performance through monthly reporting (Report 11) which is discussed at monthly joint Compliance calls. If any Compliance concerns are recognized the process is reviewed. If any issues of non-compliance arise Humana CareSource creates an internal Corrective Action Plan (CAP).
E. The average hold time is two (2) minutes or less; and		Substantial	Average hold time was under 2 minutes for all months evaluated. January 2013 Call Center report submitted by the contractor during the interview was missing the page detailing the Behavioral Health Hotline statistics, thus January 2013 data cannot be evaluated. **Recommendation to Humana CareSource/BHS** Humana CareSource/BHS should ensure that the toll-free Behavioral Health Services Hotline meets the minimum performance requirements for all Contractor Programs and Service Areas.	Humana CareSource and BHS understand the importance of ensuring that the toll-free BH hotline meets minimum performance requirements. Humana CareSource monitors the hotline performance through monthly reporting (Report 11) which is discussed at monthly joint Compliance calls. If any Compliance concerns are recognized the process is reviewed. If any issues of non-compliance arise Humana CareSource creates an internal Corrective Action Plan (CAP).

Final Report 9/5/2014

Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
F. The system can immediately connect to the local Suicide Hotline's telephone number and other Crisis Response Systems and have patch capabilities to 911 emergency services.		Full	BHS P/P UM 87.16 Response to Emergency Situations indicates patch 911 capabilities are available, as well as the ability to immediately connect to police. During interview, contractor stated that the system can immediately connect to the local Suicide Hotline.	
The Contractor may operate one hotline to handle emergency and crisis calls and routine Member calls.		Full	Addressed by BHS P/P UM 87.16 Response to Emergency Situations.	
The Contractor cannot impose maximum call duration limits and shall allow calls to be of sufficient length to ensure adequate information is provided to the Member.		Substantial	Contractor stated during the interview that contractor does not impose maximum call duration limits and ensures calls are of sufficient length to provide adequate information to member. Evidence of imposing call duration limits was not found in the documents provided however; the report "HU_Reports_140102_Report11" shows the average length of call to be 3 minutes 3 seconds. **Recommendation to Humana CareSource/BHS** Humana CareSource/BHS should include language that the MCO will not impose maximum call duration limits and shall allow calls to be of sufficient length to	Humana CareSource and Beacon will add this language in its SOPs.

Final Report 9/5/2014

Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			ensure adequate information is provided to the Member in its P/Ps.	
Hotline services shall meet Cultural Competency requirements and provide linguistic access to all Members, including the interpretive services required for effective communication.		Full	Addressed by Standard Operating Procedure (SOP) – Interpreter Services Relay Call Assistance. Addressed in BHS P/P UM 62.27 Member Services and Clinical Referral and Triage Process.	
The Behavioral Health Services Hotline may serve multiple Contractor Programs if the Hotline staff is knowledgeable about all of the Contractor Programs. The Behavioral Health Services Hotline may serve multiple Service Areas if the Hotline staff is knowledgeable about all such Service Areas, including the Behavioral Health Provider Network in each Service Area.		Minimal	Contractor stated during the interview that hotline staff is trained in the contractor programs and service areas, including provider networks. No documentation of the contract-specific training content for Kentucky Medicaid was found. **Recommendation for Humana CareSource/BHS** Humana CareSource/BHS should include in its SOP and/or P/Ps and its hotline staff training documentation that the Behavioral Health Services Hotline may serve multiple Contractor Programs and service areas and that the Hotline staff is trained regarding all of the Contractor Programs, service areas and the Behavioral Health Provider Network in each Service Area.	Humana CareSource disagrees with this finding. Beacon has a Humana CareSource specific SOP called a "training sheet" that includes the language that "the Behavioral Health Services Hotline may serve multiple Contractor Programs and service areas and that the Hotline staff is trained regarding all of the Contractor Programs, service areas and the Behavioral Health Provider Network in each Service Area." The "training sheet" was provided to auditors during the onsite interview. Final Review Determination: No change in compliance level. The SOP that lists the requirement for serving multiple programs is not sufficient evidence of compliance. Evidence of training relative to Kentucky-specific

Final Report 9/5/2014

Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
				programs and requirements is necessary to meet this element. For instance, the training materials used/provided to staff members that contain the Kentucky Medicaid material.
The Contractor shall conduct on-going quality assurance to ensure these standards are met.		Full	BHS P/P UM 87.16 Response to Emergency Situations.	
The Contractor shall monitor its performance against the Behavioral Health Services Hotline standards and submit performance reports summarizing call center performance as indicated.		Full	Addressed by Call Center Reports.	
If Department determines that it is necessary to conduct onsite monitoring of the Contractor's Behavioral Health Services Hotline functions, the Contractors responsible for all reasonable costs incurred by Department or its authorized agent(s) relating to such monitoring.				
33.7 Coordination between the Behavioral Health Provider and the PCP				
The Contractor shall require, through contract provisions, that PCPs have screening and evaluation procedures for the detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders. PCPs may provide any clinically appropriate Behavioral Health Services within the scope of their practice.		Full	Addressed by Humana CareSource's Provider Orientation Report and in the Humana CareSource Provider Manual as well as in the Humana CareSource document "Process of Educating PCPs of BH services" and embedded documents. .	
The Contractor shall provide training to network PCPs on		Full	Addressed by Humana CareSource	

Final Report 9/5/2014

Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
how to screen for and identify behavioral health disorders, the Contractor's referral process for Behavioral Health Services and clinical coordination requirements for such services. The Contractor shall include training on coordination and quality of care such as behavioral health screening techniques for PCPs and new models of behavioral health interventions.			document "Process of Educating PCPs of BH services" and embedded documents.	
The Contractor shall develop policies and procedures and provide to the Department for approval regarding clinical coordination between Behavioral Health Service Providers and PCPs.		Substantial	Addressed in BHS P/P UM 230.01 Behavioral Health Treatment and Discharge Planning, BHS P/P UM 93.12 Collaboration and Referral of Medical and Behavioral Health Cases between Beacon Health Strategies and Partner MCO, BHS P/P QM 15.16 Exchange of Information Between Behavioral Health, Primary Care Providers and Behavioral Health Practitioners and BHS P/P UM 62.27 Member Services and Clinical Referral and Triage Process. Addressed in BHS and Humana CareSource Provider Manuals. <u>BH/PH Coordination File Review</u> ▪ 10 files were reviewed. ▪ 3 files were not applicable due to inability to enroll member in care coordination despite MCO attempts to engage member. ▪ 7 of 7 applicable files included a comprehensive assessment. ▪ 7 of 7 files included a care plan.	Humana CareSource is currently drafting a SOP which will outline the provider expectation for BH and PH file sharing .

Final Report 9/5/2014

Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			▪ 5 of 7 applicable files included adequate information sharing ▪ 7 of 7 applicable files included monitoring of diagnosis, treatment, and follow-up and medication usage. ▪ 3 of 3 applicable files included case managers and other identified behavioral health service providers participating in discharge planning if the member was hospitalized (7 files were not applicable as member was not hospitalized.) ▪ 7 of 7 applicable files included identification of the physical and behavioral health needs of the member and facilitation and coordination of services with all service providers, member and family. **Recommendation for Humana CareSource/BHS** Files should contain documentation of information sharing between physical health and behavioral health providers.	
The Contractor shall require that Behavioral Health Service Providers refer Members with known or suspected and untreated physical health problems or disorders to their PCP for examination and treatment, with the Member's or the Member's legal guardian's		Full	Addressed by BHS P/P UM 62.27 Member Services and Clinical Referral and Triage Process. Addressed in Beacon Health Strategies	

Final Report 9/5/2014

Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
consent. Behavioral Health Providers may only provide physical health care services if they are licensed to do so. This requirement shall be specified in all Provider Manuals.			(BHS)/Humana CareSource Provider Manual.	
The Contractor shall require that behavioral health Providers send initial and quarterly (or more frequently if clinically indicated) summary reports of a Members' behavioral health status to the PCP, with the Member's or the Member's legal guardian's consent. This requirement shall be specified in all Provider Manuals.		Full	Addressed in Beacon Health Strategies (BHS)/Humana CareSource Provider Manual.	
33.8 Follow-up after Hospitalization for Behavioral Health Services				
The Contractor shall require, through Provider contract provision, that all Members receiving inpatient psychiatric services are scheduled for outpatient follow-up and/or continuing treatment prior to discharge.		Full	Addressed in Sample BHS Provider Contracts.	
The outpatient treatment must occur within fourteen (14) days from the date of discharge.		Full	Addressed by BHS P/P UM 230.01 Behavioral Health Treatment and Discharge Planning.	
The Contractor shall ensure that Behavioral Health Service Providers contact Members who have missed appointment within twenty-four (24) hours to reschedule appointments.		Full	Addressed in BHS/Humana CareSource Provider Manual. Partially addressed by Aftercare Program Description and Data Validation Process document - stating that an After-Care Coordinator will contact a member after a missed appointment. However, a 24-hour timeframe to contact the member is not	Humana CareSource and Beacon will add this language to its SOPs.

Final Report 9/5/2014

Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			specified in these documents. **Recommendation for Humana CareSource/BHS** A 24 hour timeframe for follow-up of missed appointments should be added to the Aftercare Program Description and Data Validation Process document.	
33.9 Court-Ordered Services				
"Court-Ordered Commitment" means an involuntary commitment of a Member to a psychiatric facility for treatment that is ordered by a court of law pursuant to Kentucky statutes.				
The Contractor must provide inpatient psychiatric services to Members under the age of twenty-one (21) and over the age of sixty-five (65), up to the annual limit, who have been ordered to receive the services by a court of competent jurisdiction under the provisions of KRS 645, Kentucky Mental Health Act of The Unified Juvenile Code and KRS 202A, Kentucky Mental Health Hospitalization Act.		~~Non Compliance~~ Full	Not addressed in documents provided. Training document addresses only that competency evaluation should be accompanied by a court order.	Humana CareSource and Beacon disagree with this finding. The language "Beacon will authorize inpatient psychiatric services to members under the age of 21 and over the age of 65, up to the annual limit, who have been ordered to receive the services by a court of competent jurisdiction under provisions of KRS 645 and KRS202A" was provided in the policy entitled "Application of Level of Care Criteria and Authorization Procedures for Medicaid Addendum for Kentucky." Final Review Determination: Full Compliance

Final Report 9/5/2014

Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
				Humana –CareSource/Beacon are correct. The P/P "Application of Level of Care Criteria and Authorization Procedures for Medicaid Addendum for Kentucky" addresses this requirement.
The Contractor cannot deny, reduce or controvert the Medical Necessity of inpatient psychiatric services provided pursuant to a Court ordered commitment for Members under the age of twenty-one (21) or over the age of sixty-five (65). Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination.		~~Non-Compliance~~ Full	Not addressed in documents provided. Training document addresses only that competency evaluation should be accompanied by a court order.	Humana CareSource and Beacon disagree with this finding. The language "Beacon will not deny, reduce, or controvert the medical necessity of inpatient psychiatric services provided pursuant to a court order commitment for members under the age of 21 and over the age of 65" was provided in the policy entitled "Application of Level of Care Criteria and Authorization Procedures for Medicaid Addendum for Kentucky." However, Humana CareSource and Beacon will add the language "Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination" to the policy. <u>Final Review Determination:</u> Full Compliance Humana –CareSource/Beacon are correct. The P/P "Application of Level of Care Criteria and Authorization Procedures for Medicaid Addendum for Kentucky" addresses this requirement.

Final Report 9/5/2014

Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
33.10 Community Mental Health Center (CMHC)				
The Contractor shall coordinate with the Community Mental Health Center (CMHC) or other qualified special health care providers, other providers of behavioral health services, and state operated or state contracted psychiatric hospitals and nursing facilities regarding admission and discharge planning, treatment objectives and projected length of stay for Members committed by a court of law to the state psychiatric hospital.		Full	Addressed by BHS P/P UM 230.01 Behavioral Health Treatment and Discharge Planning and Policy UM 233.01.	
The Contractor shall enter into a collaborative agreement with the state operated or state contracted psychiatric hospital assigned to their region in accordance with 908 KAR 3:040 and in accordance with federal Olmstead law. At a minimum the agreement shall include responsibilities of the Behavioral Health Service Provider to assure continuity of care for successful transition back into community-based supports.		Full	Addressed by sample facility contract and Policy UM 233.01.	
In addition, the Contractor Behavioral Health Service Providers shall participate in quarterly Continuity of Care meetings hosted by the state operated or state contracted psychiatric hospital.		Full	Contractor provided sample of quarterly continuity of care meeting agenda and minutes hosted by state psychiatric hospital.	
The Contractor shall ensure the Behavioral Health Service Providers assign a case manager prior to or on the date of discharge and provide case management services to Members with severe mental illness and co-occurring developmental disabilities who are discharged from a state operated or state contracted psychiatric facility or state operated nursing facility for Members with severe mental illness.		Full	Addressed by BHS P/P QM 2.14 Ensuring Continuity and Coordination of Care through Assessment, Evaluation, and Treatment Support Services.	

Final Report 9/5/2014

Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
The Case Manager and other identified behavioral health service providers shall participate in discharge planning meetings to ensure compliance with federal Olmstead and other applicable laws. Appropriate discharge planning shall be focused on ensuring needed supports and services are available in the least restrictive environment to meet the Member's behavioral and physical health needs, including psychosocial rehabilitation and health promotion.		Full	Addressed by BHS P/P QM 2.14 Ensuring Continuity and Coordination of Care through Assessment, Evaluation, and Treatment Support Services.	
Appropriate follow up by the Behavioral Health Service provider shall occur to ensure the community supports are meeting the needs of the Member discharged from a state operated or state contracted psychiatric hospital.		Full	Addressed by BHS P/P QM 2.14 Ensuring Continuity and Coordination of Care through Assessment, Evaluation, and Treatment Support Services.	
The Contractor shall ensure the Behavioral Health Service Providers assist Members in accessing free or discounted medication through the Kentucky Prescription Assistance Program (KPAP) or other similar assistance programs.		~~Minimal~~ Not Applicable	During interview, contractor stated members are able to access medications with no co-pays from the contractor. **Recommendation to Humana CareSource/BHS** Humana CareSource/BHS should include the requirement for providers to assist Members in accessing free or discounted medication through the Kentucky Prescription Assistance Program (KPAP) or other similar assistance programs in the BHS Provider Services Agreement and/or the BHS/Humana CareSource Provider Manual.	Humana CareSource disagrees with this finding. Humana CareSource provides access to medications for no co-pay to all members. The concern with encouraging providers to use other programs is that the full medical history and prescription use of a member will not be known to Humana CareSource hindering care management programs. We feel that it is in the best interest of the member that the $0 co-pay benefit of their plan be utilized so that we are able to best serve our members. Final Review Determination: Not Applicable Humana-CareSource is correct. Access to

Final Report 9/5/2014

Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
				medications with no co-pay fulfills this requirement, as additional assistance is not applicable.
33.11 Program and Standards				
Appropriate information sharing and careful monitoring of diagnosis, treatment, and follow-up and medication usage are especially important when Members use physical and behavioral health systems simultaneously. The Contractor shall:				
A. Establish guidelines and procedures to ensure accessibility, availability, referral and triage to effective physical and behavioral health care, including emergency behavioral health services, (i.e. Suicide Prevention and community crisis stabilization);		Full	Addressed by UM 62.27 Member Services and Clinical Referral and Triage Process and UM 87.16 Response to Emergency Situations.	
B. Facilitate the exchange of information among providers to reduce inappropriate or excessive use of psychopharmacological medications and adverse drug reactions;		Full	Addressed by Pharmacy and Therapeutics Committee Charter, Policy Rx-45 and Policy FW-05.	
C. Identify a method to evaluate the continuity and coordination of care, including member-approved communications between behavioral health care providers and primary care providers;		Full	Addressed by BHS P/P QM 2.14 Ensuring Continuity and Coordination of Care through Assessment, Evaluation, and Treatment Support Services.	
D. Protect the confidentiality of Member information and records; and		Full	Addressed by the BHS Kentucky Quality Improvement Program Description (QIPD) MCD Addendum.	

Final Report 9/5/2014

Behavioral Health Services (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
E. Monitor and evaluate the above, which shall be a part of the Quality Improvement Plan.		Full	Addressed by the BHS Kentucky Quality Improvement Program Description (QIPD) MCD Addendum. Since this is the first year of operation, results would not be available at the time of the onsite review.	
The Department and DBHDID shall monitor referral patterns between physical and behavioral providers to evaluate coordination and continuity of care. Drug utilization patterns of psychopharmacological medications shall be closely monitored. The findings of these evaluations will be provided to the Contractor.				

KY EQRO ANNUAL REVIEW
March 2014
Period of Review: January 1, 2013 – December 31, 2013
MCO: Humana CareSource

Final Report 9/5/2014

Behavioral Health Services

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	44	7	1	0
Total Points	132	14	1	0

Overall Compliance Determination:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Range	**3.0**	**2.0 – 2.99**	**1.0 – 1.99**	**0 – 0.99**
Points Average		**2.83**		

As part of the review IPRO assessed the MCO's implementation of any actions proposed by the MCO in response to last year's findings. It should be noted that deficiencies previously identified that continue to be deficient in the current review may adversely affect the scoring of a requirement.

Reviewer Decision:

Full Compliance	MCO has met or exceeded requirements
Substantial Compliance	MCO has met most requirements but may be deficient in a small number of areas
Minimal Compliance	MCO has met some requirements but has significant deficiencies requiring corrective action
Non- Compliance	MCO has not met the requirements
Not Applicable (NA)	Statement does not require a review decision; for reviewer information purposes

Shading of Review Determination Column Only=Not subject to review, e.g., header, DMS responsibility
Shading of Columns for Review Determination, Comments and Health Plan's and DMS's Responses and Plan of Action=Not subject to review for the current review year, e.g., standard deemed due to full compliance achieved during prior review

Behavioral Health Services
Suggested Evidence

Documents

Policies/procedures for:

- Behavioral Health services
- Clinical coordination between BH services providers and PCPs
- BH provider program capacity requirements
- BH services hotline
- Court-ordered services
- Case management services for members including discharge planning
- Accessing free or discounted medication

Benefit Summary (covered/non-covered BH services)
Provider Manual
Sample PCP contract
Sample BH provider contract
Process for educating members of where and how to obtain BH services
Process for monitoring compliance with hotline requirements
Process for educating PCPs of BH services/requirements
Evidence of training of PCPs regarding BH services/requirements
Sample participation agreement with CMHCs
Sample collaborative agreement with state operated or state contracted psychiatric hospitals
Process for coordination of services for members committed by court of law to the state psychiatric hospital
Guidelines/procedures ensuring accessibility, availability, referral and triage including emergency BH services
Process for facilitating the exchange of pharmaceutical information among providers
Process for evaluating continuity and coordination of care among providers

QI Plan
Process for monitoring BH providers participation in quarterly Continuity of Care meetings hosted by the state operated or state contracted psychiatric hospital.

Reports
Reports of access and availability of BH providers
Provider program capacity/program mapping reports
Evidence of monitoring of compliance with hotline requirements
Evidence of ensuring follow-up after hospitalization for BH services
Evidence of monitoring compliance with BH standards

KY EQRO ANNUAL REVIEW
March 2014
Period of Review: January 1, 2013 – December 31, 2013
MCO: Humana CareSource

Final Report 9/5/2014

Pharmacy Benefits (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
31.1 Pharmacy Requirements			**General Recommendation for Humana CareSource:** Policies, procedures, reports and documents should be consistent with regard to branding/MCO name and specific to Kentucky Medicaid. The full MCO name, Humana CareSource, should be used consistently.	Humana-CareSource is in the process of reviewing policies, procedures, reports, and documents to ensure branding consistency with the "Humana-CareSource" name and logo. Additionally, we are reviewing all policies and procedures to ensure they are Kentucky Medicaid specific.
The Contractor shall provide pharmacy benefits in accordance with this section in addition to other requirements specified in this contract. Pharmacy benefit requirements shall include, but not be limited to:				
A. State-of-the-art, online and real-time rules-based point-of-sale (POS) Claims processing services with prospective drug utilization review including an accounts receivable process;		Full	Evidence of this requirement was provided in the following policies and procedures and documentation: CareSource: - RX-47 Pharmacy – Preferred Drug List and Clinical UM Evaluation - RX- 45 Pharmacy - Clinical Utilization Management Pharmacy Edits - 2013 HUM CS Kentucky Provider Manual CareMark: - Pharmacy claims	

Final Report 9/5/2014

Pharmacy Benefits (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			processing engine diagram - PROFPR-0043 Processing DUR and DDI Edits PP	
B. Retrospective utilization review services;		Substantial	P/Ps addressing retrospective DUR were not provided. MCO reports regarding drug utilization review (30, 40B, 41, 42A, 42B, 42C, 43, 44, 45A, 45B, 59) were provided. **Recommendation for Humana CareSource**: Develop a P/P to address retrospective DUR activities.	Humana - CareSource agrees with the recommendation and has developed a new DUR Policy, inclusive Retrospective Drug Utilization Review, which goes to the P&P committee for approval in August 2014.
C. Formulary and non-formulary services, including prior authorization services;		Full	Addressed in "CareSource" policies and procedures: - RX-26 Pharmacy-Prior Authorization Request Handling - RX-47 Preferred Drug List and Clinical UM Evaluation, - RX-29 Pharmacy – Quality Monitoring of Pharmacy Utilization Management - RX-16 Pharmacy - Accessibility of Review Services. RX- 29 Pharmacy – Quality Monitoring	

Final Report 9/5/2014

Pharmacy Benefits (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			of Pharmacy Utilization Management provides for evaluation of the quality of prior authorization services and quality of telephonic communication. MCO reports #39 (Monthly Formulary Management) and #59 (Prior Authorizations) were provided.	
D. Pharmacy provider relations and call center services, in addition to Provider Services specified elsewhere; and		Full	Addressed by - CareSource P/P RX- 29 Pharmacy Quality Monitoring of Pharmacy Utilization Management - 2013 HUM CS Kentucky Provider Manual - CareMark CALL-0049 Customer Care Call Handling PP	
E. Seamless interfaces with the information systems of the Commonwealth and as needed, any related vendors.		Full	Addressed by: CareSource: - RX-47 Pharmacy – Preferred Drug List and Clinical UM Evaluation - RX-45 Pharmacy - Clinical Utilization Management Pharmacy Edits - 2013 HUM CS Kentucky Provider Manual. CareMark	

Final Report 9/5/2014

Pharmacy Benefits (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			- Pharmacy claims processing engine diagram - PROFPR-0043 Processing DUR and DDI Edits PP	
31.2 Formulary and Non-Formulary Services				
The Contractor shall maintain a preferred drug list and make information available to pharmacy providers and Members the co-pay tiers or other information as necessary.		Full	Addressed by: - Preferred Drug List - RX-46 Pharmacy – Generic and Formulary Management - Flowchart Pharmacy – Formulary Management Processes - RX- 47 Pharmacy – Preferred Drug List and Clinical UM Evaluation	
The Contractor shall utilize a Pharmacy and Therapeutics Committee (P&T Committee). The committee shall meet periodically throughout the calendar year as necessary and make recommendations to the Contractor for changes to the drug formulary.		Full	Addressed including the provision for public input by P&T committee charter and minutes: - Pharmacy and Therapeutics Committee Charter 2013 (delineates composition, reporting structure and provision for public input). - Kentucky Pharmacy and Therapeutics Committee August 2013 Minutes - Kentucky Pharmacy and Therapeutics Committee Feb 2013 Minutes	

Final Report 9/5/2014

Pharmacy Benefits (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			- Kentucky Pharmacy and Therapeutics Committee May 2013 Minutes - Kentucky Pharmacy and Therapeutics Committee Nov 2013 Minutes "CareSource" P/Ps: - RX-47 Pharmacy – Preferred Drug List and Clinical UM Evaluation	
The Contractor shall provide information to its pharmacy providers regarding the Preferred Drug List (PDL) for Medicaid Members. This list updated by the Contractor throughout the year shall reflect changes in the status of a drug or to the addition of new drugs, as required.		Full	The following policies and procedures and documentation satisfy this requirement: - "CareSource KY 1013 fmt sec apvd" (Provider Formulary Manual) - RX- 47 Pharmacy – Preferred Drug List and Clinical UM Evaluation (online updates) - Formulary Change Letter to Providers (written letter updates) - KY-MMED-317 Formulary Change Letter to Members (written letter updates).	
31.3 Pharmacy Claims Administration				
The Contractor shall process, adjudicate, and pay pharmacy Claims for Members via an online real-time POS system,		Full	The following policies and procedures and documents satisfy this	

Final Report 9/5/2014

Pharmacy Benefits (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
including voids and full or partial adjustments. The Contractor shall maintain prospective drug utilization review edits and apply these edits at the POS. The Contractor shall be responsible for processing components required for paper Claims.			requirement: CareSource: - RX-47 Pharmacy – Preferred Drug List and Clinical UM Evaluation - RX-45 Pharmacy - Clinical Utilization Management Pharmacy Edits - 2013 HUM CS Kentucky Provider Manual CareMark: - Pharmacy claims processing engine diagram - PROFPR-0043 Processing DUR and DDI Edits PP	
The Contractor maintains, through an online system, appropriate accounts receivable (A/R) records for the Commonwealth to systematically track adjustments, recoupments, manual payments and other required identifying A/R and Claim information.		Full	The following policies and procedures and documents satisfy this requirement: CareSource: - RX-47 Pharmacy – Preferred Drug List and Clinical UM Evaluation - RX-45 Pharmacy - Clinical Utilization Management Pharmacy Edits - 2013 HUM CS Kentucky Provider Manual	

Final Report 9/5/2014

Pharmacy Benefits (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
			CareMark - Pharmacy claims processing engine diagram - PROFPR-0043 Processing DUR and DDI Edits PP	
The Contractor shall interface with the Commonwealth's information systems to provide data and other information, as needed, to properly administer the pharmacy benefit program.		Full	The following policies and procedures and documents satisfy this requirement: CareSource: - RX-47 Pharmacy – Preferred Drug List and Clinical UM Evaluation - RX-45 Pharmacy - Clinical Utilization Management Pharmacy Edits CareMark: - Pharmacy claims processing engine diagram - PROFPR-0043 Processing DUR and DDI Edits PP	
31.4 Pharmacy Rebate Administration				
The Patient and Affordable Care Act (PPACA) signed into law in March 2010 require states to collect CMS level rebates on all Medicaid MCO utilization. In order for the Department to comply with this requirement the Contractor shall be required to submit NDC level information including J-code conversions		Non-Compliance	Evidence of this requirement was not provided either in policy and procedure or documentation. **Recommendation for Humana**	Humana – CareSource agrees with the recommendation and has developed a new Rebate Policy which goes to the P&P committee for approval in August

Final Report 9/5/2014

Pharmacy Benefits (*See Final Page for Suggested Evidence*)				
State Contract Requirements (Federal Regulation: Not Applicable)	**Prior Results & Follow-Up**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**Health Plan's and DMS' Responses and Plan of Action**
consistent with CMS requirements. The Department will provide this Claims level detail to manufacturers to assist in dispute resolutions. However, since the Department is not the POS Claims processor, resolutions of unit disputes are dependent upon cooperation of the Contractor. The Contractor shall assist the Department in resolving drug rebate disputes with the manufacturer. The Contractor also shall be responsible for rebate administration for pharmacy services provided through other settings such as physician services.			**CareSource** Humana CareSource should develop a policy/procedure addressing the following: - assist the Department in resolving drug rebate disputes with the manufacturer - be responsible for rebate administration for pharmacy services provided through other settings such as physician services.	2014. The P&P is inclusive of : - How Humana - CareSource will assist the Department in resolving drug rebate disputes with the manufacture, - Also, Humana - CareSource will be responsible for administration of rebates on pharmaceuticals provided through non-pharmacy settings such as physician services.
37.12 Prospective Drug Utilization Review Report				
The Contractor shall perform Prospective Drug Utilization Review (Pro-DUR) at the POS. They also provide Retrospective Drug Utilization Review (Retro-DUR) services by producing multiple reports for use by the Department.		Substantial	Prospective DUR addressed in P/P: RX-47 Pharmacy – Preferred Drug List and Clinical UM Evaluation Policies and procedures regarding retrospective review were not provided. The following MCO reports include retrospective review documentation: 30, 40B, 41, 42A, 42B, 42C, 43, 44, 45A, 45B, 59. **Recommendation for Humana CareSource**:	Humana - CareSource agrees with the recommendation and has developed a new DUR Policy, inclusive Retrospective Drug Utilization Review, which goes to the P&P committee for approval in August 2014**.**

Final Report 9/5/2014

Pharmacy Benefits (*See Final Page for Suggested Evidence)*				
State Contract Requirements (Federal Regulation: Not Applicable)	Prior Results & Follow-Up	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	Health Plan's and DMS' Responses and Plan of Action
			Develop a P/P to address retrospective DUR activities.	

Final Report 9/5/2014

Pharmacy Benefits

Scoring Grid:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Value	**3**	**2**	**1**	**0**
Number of Elements	10	2	0	1
Total Points	30	4	0	0

Overall Compliance Determination:

Compliance Level	Full	Substantial	Minimal	Non-Compliance
Points Range	**3.0**	**2.0 – 2.99**	**1.0 – 1.99**	**0 – 0.99**
Points Average		**2.62**		

As part of the review IPRO assessed the MCO's implementation of any actions proposed by the MCO in response to last year's findings. It should be noted that deficiencies previously identified that continue to be deficient in the current review may adversely affect the scoring of a requirement.

Reviewer Decision:

Full Compliance	MCO has met or exceeded requirements
Substantial Compliance	MCO has met most requirements but may be deficient in a small number of areas
Minimal Compliance	MCO has met some requirements but has significant deficiencies requiring corrective action
Non- Compliance	MCO has not met the requirements
Not Applicable (NA)	Statement does not require a review decision; for reviewer information purposes

Shading of Review Determination Column Only=Not subject to review, e.g., header, DMS responsibility
Shading of Columns for Review Determination, Comments and Health Plan's and DMS's Responses and Plan of Action=Not subject to review for the current review year, e.g., standard deemed due to full compliance achieved during prior review

Final Report 9/5/2014

Pharmacy Benefits
Suggested Evidence

Documents

Policies/procedures for:

- Pharmacy benefit requirements
- Structure of pharmacy program
- Pharmacy claims administration
- Pharmacy rebate administration
- Prospective and retrospective drug utilization review
- Pharmacy restriction program

Preferred Drug List
Listing of drugs requiring prior authorization
Pharmacy & Therapeutics Committee description, membership, meeting agendas and minutes
Process for informing members and pharmacy providers of preferred drug list and related information
Process for evaluating the impact of the pharmacy program on members
Prior authorization process

Reports

Retrospective Drug UR reports